STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44978 Based on interview and record review the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level 1 was completed accurately 1 of 1 Residents (Resident #84). The facility failed to provide a PASRR level I screening for Resident #84 upon admission who had a mental health diagnosis which would have triggered the completion of a PASRR level 1 screening. This failure could place residents who had a positive PASRR Level 1 screening at risk for not receiving care and service to meet their needs. Findings included: Review of Resident #84's face sheet revealed an admitted [DATE], with diagnoses that included: heart failure, cognitive communication disorder, and post traumatic disorder. Review of Resident #84's MDS dated [DATE] revealed that the resident had a BIMS of 10, which indicated that the resident had moderately impaired cognition. Interview with MDS Coordinator H on 03/14/2024 at 12:45 p.m., while looking at the paper copy of the PASRR screening completed and sent to the facility by the referring entity revealed both the yes and no boxes checked for mental illness were checked. MDS Coordinator H stated she is now responsible for entering all PASRR screenings for residents into another database to ensure they receive the proper screening, however the employee that was responsible for ensuring Resident #84 received an initial PASRR screening upon admission is not longer employed with the facility, she did not know if the referring entity was called for clarity on the initial PL-1 but stated Resident #84 should have received a PASRR screening from the local authority to determine if eligible for PASRR services. MDS Coordinator H further stated the resident did not receive the proper screening because the facility staff responsible for completing the assessments at that time did not ensure accuracy of the received or transmitted data at the time of admission and did not follow up although Resident #84 was admitted with a diagnosis of post traumatic stress disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 03/13/2024 at 1:05 p.m., while looking at Resident the PL-1, (PASRR screening) completed and sent to the facility by the referring entity revealed both the yes and no boxes checked for mental illness were checked. The DON stated MDS Coordinator H is now responsible for ensuring all PASRR screenings are completed and entered accurately and if there is a question regarding information submitted to the facility by the referring entity she should follow up with them to ensure accuracy. The DON further stated, the PASRR screening for Resident #84 on section C of the PL-1 is incorrect, it is checked yes and no and only one answer should have been checked; Resident #84 has an admitting diagnosis of post traumatic stress disorder, the MDS Coordinator should have let the referring entity to see if they could clarify and do a new screening and the form 1012 so the authority would have come to the facility and complete the evaluation the resident was supposed to receive. The DON said she did not believe the resident not receiving the PASRR screening affected the resident in anyway and did not believe the resident would receive PASRR services when screened. A policy for PASRR screening was requested during this interview. Shortly after the interview and prior to facility exit, the DON returned and said the facility did not have a specific policy related to the completion of PASRR screenings for residents it was a practice that is governed by state rules.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care for one of nineteen residents (Residents #251) reviewed for baseline care plan. The facility failed to provide Resident #251 with perineal care after deactivating Resident #251's call light. This deficient practice could place residents at risk for not having care and services provided to meet their needs. The findings included: Record review of Resident #251's face sheet, dated 03/15/2024 reflected an [AGE] year-old male admitted on [DATE] to room [ROOM NUMBER] with a primary diagnosis of Alzheimer disease, unspecified (a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment.) Record review of Resident #251's baseline care plan, dated 03/12/2024, reflected Resident #251 required assistance with toileting and preferred to not utilize an adult brief. Interview on 03/12/2024 at 3:20 PM, Resident #251's family member stated Resident #251 just admitted from the hospital for short-term rehabilitation and had difficulty with having staff assist Resident #251 with brief changes promptly in the last two days; she stated administration had resolved it for the day but still occasionally had this problem. Resident #251's family member stated Resident #251 used the call light just about five minutes ago upon which an unknown staff member responded to the call light and deactivated it before leaving the room and not assisting with the brief change while promising a different staff would arrive shortly for assistance. Observation on 03/12/2024 from 3:22 PM to 3:51 PM revealed no staff responded to Resident #251's need for assistance. Interview on 03/12/2024 at 3:52 PM, LVN I stated she did not respond to Resident #251's call light and was not informed of any need for assistance for Resident #251 by another staff member, and stated the protocol for staff responding to call lights was in the instance the responding staff member could not assist with the immediate need, they were to inform another staff member who could respond immediately to ensure the resident's needs were met. LVN I stated the two CNAs working on the 300-hall were CNA J and CNA K. Interview on 03/12/2024 at 4:01 PM, CNA J stated she did not respond to a call light for Resident #251 and was not informed of any need for assistance for Resident #251 by another staff member. CNA J stated her standard practice if she could not immediately help a resident would be to inform another staff who could assist that resident immediately. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/12/2024 at 4:10 PM, CNA K stated she did not respond to a call light for Resident #251 and was not informed of any need for assistance for Resident #251 by another staff member. CNA K stated her typical practice was if she responded to a call light and could not assist, then she would ask another staff to assist the resident immediately. Interview on 03/12/2024 at 4:14 PM, Resident #251's family member stated she observed the staff member who originally responded to the call light as the DOR. Interview on 03/12/2024 at 4:20 PM, the DOR stated she did not respond to a call light for Resident #251 and had not been asked for assistance to perform a brief change. The DOR stated she had been at the hallway desk to assist the charge nurses and aides in responding to call lights, but she informed appropriate staff to assist with care requests. Interview on 03/12/2024 at 4:49 PM, the DON stated she was made aware of the concern related to Resident #251 but stated she was not able to determine who the responding staff was. The DON stated regardless of who responded to the call light, a staff in general should have responded to assist the resident with the brief change. The DON stated it was her expectation that any staff who respond to the call light are to assist the resident with their care needs if it is within their ability at the time, however if they could not, then to inform a different staff member to assist the resident with their request. The DON stated the potential risk associated with not assisting a resident with a brief change immediately could be skin breakdown from the bowel movement or negative sentiment from the resident. Record review of facility policy titled Rounds & Staffing, undated, reflected: 1. Residents will be checked by the nursing staff frequently and answering call lights in a timely manner.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 2 of 22 residents (Resident #16 and #8) reviewed for care plans in that: 1. Resident #16's comprehensive care plan did not reflect the resident was no longer receiving hospice services. 2. Resident #8's comprehensive care plan did not reflect the resident was not using a leg/foot brace. These failures could place residents at risk of receiving inadequate interventions not individualized to their care needs. The findings included: 1. Record review of Resident #16's face sheet, dated 3/14/24 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included senile degeneration of brain (late onset dementia), type 2 diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), hypertension (high blood pressure), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), oral phase dysphagia (problems with using the mouth, lips and tongue to control food or liquid), need for assistance with personal care and acute respiratory failure with hypoxia (not enough oxygen in the blood, but levels of carbon dioxide are close to normal). Record review of Resident #16's most recent Significant Change MDS assessment, dated 1/12/24 revealed the resident was severely cognitively impaired for daily decision-making skills and was not receiving hospice services. Record review of Resident #16's Order Audit Report, dated 3/14/24 revealed the resident discontinued hospice services on 2/16/24. Further review of the Order Audit report revealed the following: Discontinue resident family fired hospice company. Record review of Resident #16's comprehensive care plan, with revision date 9/14/23 revealed the resident was inaccurately receiving hospice services related to senile degeneration of the brain with interventions that included to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs were met. During an interview with Resident #16's family member on 3/13/24 at 12:12 p.m., revealed the family had fired the hospice team approximately two weeks ago because they were not satisfied with the hospice services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/24 at 4:11 p.m., the SW stated, Resident #16's family member terminated hospice services because the family was not satisfied with the hospice services. During an interview on 3/14/24 at 1:58 p.m., LVN A revealed Resident #16 used to receive hospice services but the services were terminated on 2/16/24. During a follow up interview on 3/14/24 at 2:07 p.m., the Social Worker revealed Resident #16's care plan should have been updated to reflect the resident was no longer receiving hospice services. The Social Worker further revealed she was responsible for updating the comprehensive care plan because the discussion to discontinue hospice services was revealed during a care plan meeting with Resident #16's family. The Social Worker stated it was important to ensure the comprehensive care plan was updated because it showed how to address the resident's problems. During an interview on 3/14/24 at 5:38 p.m., the DON stated Resident #16 used to receive hospice services but they were fired by the family member. The DON further revealed, Resident #16's comprehensive care plan should have been updated to reflect the resident was no longer receiving hospice services. The DON revealed it was important to update the comprehensive care plan because it was part of the record that was patient centered so everyone can know how to care for the patient. The DON revealed, the Social Worker had made herself responsible, but nursing also could have done it (update the comprehensive care plan), we're all responsible. 2. Record review of Resident #8's face sheet, dated 3/14/24 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pressure ulcer of right heel stage 4 (wound that exposed underlying muscle, tendon, cartilage or bone), type 2 diabetes, hyperlipidemia (elevated cholesterol levels), dementia, seizures (central nervous system (neurological) disorder in which brain activity becomes abnormal, causing seizures or periods of unusual behavior, sensations and sometimes loss of awareness), pain and cerebral infarction (also known as a stroke; damage to tissues in the brain due to loss of oxygen to the area). Record review of Resident #8's most recent quarterly MDS assessment dated [DATE] revealed the BIMS score was a 9 which indicated the resident was moderately impaired for daily decision-making skills and had a stage 4 pressure ulcer. Record review of Resident #8's Order Summary Report, dated 3/14/24 revealed the following orders: - Patient to wear multi podus boot (the gray rigid brace) to R/L foot with anti-roll stand in place and toe guard to offload heel and protect toes from blanket, with order date 11/21/23 and no end date - Wound care to right heel, Pressure Ulcer Stage 4: Cleanse with Wound Cleanser, pat dry with gauze, apply skin prep to peri wound. Apply Calcium Alginate with AG (silver) to wound bed, then 4 x 4 kerlix in place, change daily and as needed for wound care with order date 1/16/24 and no end date Record review of Resident #8's comprehensive care plan, with revision date 6/16/23 revealed the resident had a right heel pressure injury with interventions that included to administer treatments as ordered and Resident #8 to wear multi podus boot (the gray rigid brace) to right foot with anti-roll stand in place and toe guard to offload heel and protect toes from blanket (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/12/24 at 9:35 a.m., Resident #8 revealed he had wounds but was not sure if the wounds were being treated. Resident #8 further revealed he was not able to get in and out of bed because he was paralyzed. Resident #8 was observed in bed wearing soft offloading boots to both feet and there were two gray leg braces on the seat of the resident's wheelchair across from the bed. During an observation on 3/14/24 at 8:12 a.m., Resident #8 was observed in the bed wearing soft offloading boots to both feet and there were two gray leg braces on the seat of the resident's wheelchair across from the bed. During an observation and interview on 3/14/24 at 8:25 a.m., LVN Treatment Nurse B revealed Resident #8 wore soft offloading boots to both feet but used to wear the podus boot which was a brace but should only be using the soft offloading boots because the podus boot was causing more harm to the area rather than helping the wound to heal. The TX Nurse revealed the order for the podus boot should have been discontinued and the comprehensive care plan should have been updated to reflect the podus boot was no longer being used. LVN Treatment Nurse B stated it was important to update the comprehensive care plan because it would reflect the type of care in place, so everyone was consistent with Resident #8's care. LVN Treatment Nurse B revealed she was responsible for updating Resident #8's care plan and orders and the changes should have been updated immediately. During an interview on 3/14/24 at 10:59 a.m., PT E revealed Resident #8 used to use the podus boot while sitting up in the wheelchair, but the resident could no longer tolerate sitting up in the wheelchair. PT E revealed the order for the podus boot was a general order and should have been discontinued when the soft offloading boots were being utilized. During an interview on 3/14/24 at 5:45 p.m., the DON revealed, Resident #8's comprehensive care plan should have been updated to reflect the resident was no longer wearing the podus boot. The DON revealed it was important to update the comprehensive care plan because it was part of the record that was patient centered so everyone can know how to care for the patient. The DON revealed everyone was responsible for updating the comprehensive care plan. Record review of the facility policy and procedure titled, Comprehensive Person-Centered Care Planning, with revision date 12/2023 revealed in part, .It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs .The resident has the right to refuse or discontinue treatment .In the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk .The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 32 resident (Resident #261) reviewed for accidents and hazards. The facility failed to remove a syringe with open needle attached from Resident #261's room. This deficient practice could place residents at risk of harm or injury and contribute to avoidable accidents. The findings included: Record review of Resident #261's face sheet, dated 03/14/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] to room [ROOM NUMBER]-A with a primary diagnosis of encounter for surgical aftercare following surgery on the circulatory system. Record review of Resident 261's baseline care plan, dated 03/09/2024, reflected Resident #261 was independently ambulatory and received medications administered by nursing staff. Record review of Resident #261's order summary, dated 03/14/2024, reflected no medications administered via syringe or injection. Observation and interview on 03/13/2024 at 11:11 AM, revealed a syringe with needle attached inside an opened package resting on the bedside nightstand in room [ROOM NUMBER]. Resident #261 stated he had not seen the syringe on his bedside nightstand and stated he did receive an insulin injection that morning however they did not use a syringe and instead used an insulin-pen. Interview on 03/13/2024 at 11:15 AM, LVN L stated he was not aware of the syringe in room [ROOM NUMBER] and stated he had last rounded on the resident earlier this morning to provide him his insulin but stated he received it via an insulin pen. LVN L stated the syringe should not have been left in the room but stated he was not sure where the syringe would have been left from as Resident #261 did not receive any treatments or medications that would have utilized a syringe. LVN L stated the syringe did not appear to have been used as he did not observe any residual fluid in the syringe. LVN L stated he would dispose of the syringe immediately in the sharps container. Interview on 03/13/2024 at 4:09 PM, the DON stated she was made aware of the discovery of the syringe in room [ROOM NUMBER] but stated she was not able to identify which staff left the syringe but stated regardless of the staff responsible, the syringe should not have been left in Resident #261's room regardless as it presented a danger and risk for potential accident sticking without knowing if the needle was used or not. Record review of facility policy titled Rounds & Staffing, undated, reflected: 5. Observe physical environment to ensure personal items are safe for the resident that are kept at bedside, such as nail clippers, razors, etc.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review the facility failed to ensure residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 1 resident (Resident #80) reviewed for gastrostomy tube management. The facility failed to ensure Resident #80 was provided with the correct water flushes before and after medication administration through a gastrostomy tube (g-tube, feeding tube). This failure could place residents who received medications by gastrostomy tube at risk for injury, aspiration into the lungs (fluid or food enter the lungs accidently), decreased quality of life, hospitalization and decline in health. The findings included: Record review of Resident #80's face sheet, dated 3/14/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), muscle wasting, gastroparesis (a condition that affects the stomach muscles and prevents proper stomach emptying), nausea with vomiting, heart failure, gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach [esophagus), and dysphagia oropharyngeal phase (difficulty swallowing occurring in the mouth and/or the throat). Record review of Resident #80's most recent quarterly MDS assessment, dated 12/20/23 revealed the resident was moderately cognitively impaired for daily decision-making skills and required a feeding tube. Record review of Resident #80's Order Summary Report, dated 3/14/24 revealed the following: - NPO (Nothing by mouth), with order date 12/16/23 and no end date -Enteral Feed Order every shift check g-tube placement and patency prior to each feeding/flushing/medication administration, with order date 12/16/23 and no end date -Enteral Feed Order every shift, flush g-tube with 30-50 ml (milliliters) of water before and after medication administration, with order date 12/16/23 and no end date -Flush peg tube (g-tube) with 180 ml of water every 6 hours, with order date 12/27/23 and no end date Record review of Resident #80's comprehensive care plan, revision date 12/17/23 revealed the resident had a g-tube in place related to a nutritional problem and diabetic gastroparesis and gastroesophageal reflux, with interventions that included water flushes via g-tube of 180 ml every 6 hours. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation during the medication pass on 3/14/24 at 9:12 a.m. revealed LVN A, after checking for g-tube placement to Resident #80, attempted to flush the g-tube with 5 ml of water instead of the ordered 30 ml to 50 ml of water prior to medication administration, but could not get the water to drain into the g-tube because it was clogged. LVN A then emptied the 5 ml of water from the syringe and left the bedside to retrieve a new attachment for the g-tube. LVN A then again poured 5 ml of water instead of the ordered 30 ml to 50 ml of water prior to medication administration but could not get the water to drain into the g-tube. LVN A then emptied the syringe with 5 ml of water and left the bedside. LVN A then returned with a cup of gauze and poured normal saline into the cup. LVN A then cleaned Resident #80's g-tube stoma and placed a split sponge on the site. LVN A then replaced the attachment on the g-tube and checked for residual. LVN A then flushed the g-tube with 15 ml of water instead of the ordered 30 ml to 50 ml of water prior to medication administration and administered Resident #80's medications via the g-tube. At the end of the medication administration, LVN A then administered a final flush of 180 ml into Resident #80's g-tube instead of the ordered 30 ml to 50 ml of water. During an interview and observation on 3/14/24 at 10:13 a.m., LVN A revealed she had attempted to flush Resident #80's g-tube with 5 ml of water to ensure the water went into the g-tube by gravity but after reviewing the physician's orders realized she should have flushed the g-tube with 30 ml to 50 ml of water before and after medication administration. After reviewing Resident #80's orders in the computer realized the 180 ml of water flush was supposed to be given every 6 hours and did not apply to the medication administration. LVN A could not elaborate on how the inaccurate administration of the water flush would affect the resident. During an interview on 3/14/24 at 5:21 p.m., the DON revealed it was her expectation that the nursing staff follow the physician's orders when providing water flushes during the medication pass to Resident #80's g-tube. The DON revealed, if Resident #80 was not getting the correct water flushes it could result in the resident not getting enough or too much hydration. Record review of the facility policy and procedure titled, Medication Administration via Feeding Tube, revision dated 12/2023 revealed in part, .It is the policy of this facility to ensure that medications administered via feeding tube are administered safely and accurately .A physician's order is required for the administration of any medication via feeding tube .The order must specify .volume of water to be administered with the medication .The amount of water used to flush, mix and administer the medication must be considered when calculating the total free water prescribed by the physician .Flush the feeding tube with at least 30 ml of water or other prescribed flush .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on record review and interviews, the facility failed to ensure residents were given psychotropic medications with consent for 1 (Resident #55) of 5 Residents, reviewed for unnecessary psychotropic medications. The facility failed to obtain written consent before providing Resident #55 with Zoloft (an antidepressant used to treat depression). This deficient practice could affect residents who received psychotropics in the facility and put them at risk for adverse consequences such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. The findings included: Record review of Resident #55's face sheet, dated 03/14/2024, reflected an [AGE] year-old female admitted on [DATE] with a primary diagnosis of Postprocedural seroma of a circulatory system organ or structure following a circulatory system procedure (an abnormal accumulation of fluid in a circulatory system organ such as the heart) in addition to a diagnosis of depression. Record review of Resident #55's MDS, dated [DATE], reflected a summary BIMS score of 15, indicating cognitively intact. Record review of a psychoactive medication therapy informed consent form within Resident #55's EHR, date signed 02/28/2024, reflected empty fields for: the medication ordered, the related diagnosis, conditions treated, expected benefit, clinically significant side effects associated, or the purpose course of therapy in time. Interview on 03/14/2024 at 10:51 AM, LVN M stated the standard protocol when a new admission came into care would be to receive consent forms for any medications requiring consents such as psychotropics. She stated the psychotropic medications could not be provided until consent was obtained, and that would have been completed by the admitting nurse. LVN M stated the admitting nurse was LVN L but the consent signature was not able to be discerned in review. LVN M stated the consent form within Resident #55's EHR was incomplete and should not have been uploaded. LVN M stated the admitting nurse or whoever completed the consent form with the resident or the family should have caught the incomplete form but also the medical records. (continued on next page)

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Westover Hills Rehabilitation and Healthcare	9922 State Hwy. 151 San Antonio, TX 78251

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/14/2024 at 11:05 AM, Medical Records stated his role included uploading the medical forms that the nursing staff will leave in the outgoing paper tray to be uploaded into the resident's EHR, but also to review the forms for completion prior to uploading them. Medical Records stated when he notices the forms are incomplete was to return the form to the nurse who completed it and to have them complete the form or get the form completed prior to uploading them into the EHR. Medical Records stated he was unfamiliar with the purpose of the psychotropic consent form but stated he believed it was instrumental in providing the residents psychotropic medications appropriately. Medical Records stated the psychotropic consent form within Resident #55's EHR was incomplete and was not aware of it's completion at the time of uploading it. Medical Records stated he was not certain of the risk associated with the consent not being obtained. Interview on 03/14/2024 at 2:11 PM, the DON stated she was not previously aware of the consent form obtained for Resident #55 but stated she was made aware during the investigation. The DON stated her expectation for admitting nurses or whoever obtains consent forms related to psychotropic medications for residents would be to complete the entirety of the form to ensure the medication is thoroughly communicated to the resident or their responsible party. The DON stated it was her expectation that the nursing staff and medical records review the consent forms to determine their completion prior to uploading them to the EHR, thus certifying their completion. The DON stated each staff who has their hands on the consent from the admitting nurse, the following charge nurse, the medical records, and the IDT were all responsible for reviewing the consents for completion. Record review of the facility's psychotropic medication policy titled Psychotropic Medications, dated revised 12/2023, reflected 8. Upon change of condition or initiation of a new order for psychoactive medications, the facility will obtain consent prior to the initiation of the new medication.

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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** 39075 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles in locked compartments and permit only authorized personnel to have access to the keys for 1 of 9 Medication Carts (300 Hall Med Aide Medication Cart) reviewed for storage of drugs, and 1 of 6 residents reviewed during the medication pass in that: 1. The 300 Hall Med Aide Medication Cart was left unlocked and unattended. 2. LVN A left medications unattended at Resident #80's bedside during the medication pass. This failure could place residents at risk of medication misuse and diversion. The findings included: 1. Observation on 3/12/24 at 3:07 p.m. revealed the 300 Hall Med Aide Medication Cart was left unlocked and unattended. The 300 Hall Medication Cart was parked in a high traffic area just outside the main dining room, next to the 300 hall and in front of the nurse's station. On 3/14/24 at 3:23 p.m., the DON approached the State Surveyor and stated, I know what you're looking at and proceeded to push the button on the cart to lock the 300 Hall Med Aide Medication Cart. During an interview on 3/14/24 at 3:23 p.m., the DON revealed, Med Aide F was responsible for the 300 Hall Med Aide Medication Cart. The DON stated, Med Aide F was probably on the 400 Hall. The DON revealed the 300 Hall Med Aide Medication Cart was not supposed to be left unlocked and unattended because residents with dementia could get in the cart. 2. Record review of the Nurse Competency Checklist/Gastrostomy Tube Administration dated 7/6/23 for LVN A revealed she had satisfied the requirements for medication administration which included preparing medications to be administered and gathering all supplies at the bedside. Record review of Resident #80's face sheet, dated 3/14/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), muscle wasting, gastroparesis (a condition that affects the stomach muscles and prevents proper stomach emptying), nausea with vomiting, heart failure, gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach [esophagus]), and dysphagia oropharyngeal phase (difficulty swallowing occurring in the mouth and/or the throat). Record review of Resident #80's most recent quarterly MDS assessment, dated 12/20/23 revealed the resident was moderately cognitively impaired for daily decision-making skills and required a feeding tube. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #80's Order Summary Report, dated 3/14/24 revealed the following orders: - NPO (Nothing by mouth), with order date 12/16/23 and no end date -Enteral Feed Order every shift check g-tube placement and patency prior to each feeding/flushing/medication administration, with order date 12/16/23 and no end date -Enteral Feed Order every shift, flush g-tube with 30-50 ml (milliliters) of water before and after medication administration, with order date 12/16/23 and no end date - Enteral Feed Order every shift, may crush/combine medication for administration if not contraindicated and mix with 4 ounces of water, may use slow push to facilitate consumption, with order dated 12/16/23 and no end date - Enteral Feed Order every shift mix each medication with 5-10 ml of water then administer meds per g-tube, with order date 12/16/23 and no end date -Flush peg tube (g-tube) with 180 ml of water every 6 hours, with order date 12/27/23 and no end date - Carvedilol 12.5 mg, give 1 tablet via g-tube two times a day for high blood pressure, with order date 12/18/23 and no end date - Citalopram Hydrobromide 10 mg, give 1 tablet via g-tube one time a day for depression, with order date 12/16/23 and no end date - Cyclobenzaprine 10 mg, give 1 tablet via g-tube three times a day for muscle relaxer, with order date 12/16/23 and no end date - Eliquis 2.5 mg, give 1 tablet via g-tube two times a day for anticoagulant, with order date 12/19/23 and no end date - Famotidine 20 mg, give 1 tablet via g-tube two times a day for gastro-esophageal reflux disease without esophagitis, with order date 12/16/23 and no end date - Folic Acid 1 mg, give 1 tablet via g-tube one time a day for supplement, with order date 12/18/23 and no end date - Gabapentin 300 mg, give 1 capsule via g-tube three times a day related to polyneuropathy, with order date 12/18/23 and no end date - Lactobacillus, give 1 capsule via g-tube three times a day for probiotic, with order date 12/16/23 and no end date Record review of Resident #80's comprehensive care plan, revision date 12/17/23 revealed the resident had a peg tube in place related to a nutritional problem and diabetic gastroparesis and gastroesophageal reflux, with interventions that included water flushes via g-tube of 180 ml every 6 hours. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/14/24 at 9:12 a.m., during the medication pass revealed LVN A crushed and mixed 8 of Resident #80's medications with water and placed them on the resident's bedside table in 8 separate cups. LVN A, left the resident's room on three different occasions and closed the door behind her while she went to the medication cart to gather supplies and left the resident's medications on the bedside table. During an interview on 3/14/24 at 10:13 a.m., LVN A stated she should not have left Resident #80's medications at the bedside because somebody could have accidentally knock them over and she was not supposed to leave the medications from her sight. During an interview on 3/14/24 at 5:21 p.m., the DON revealed she expected the staff not leave any medications unattended because a resident with dementia could accidently take the medication, anybody could take it. Record review of the facility policy and procedure titled, Care and Treatment; Medication Access and Storage, revision date 8/2020 revealed in part, .It is the policy of this facility to store all drugs and biologicals in locked compartments .The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications .Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access .

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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. 36232 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, in that: 1. There was a gallon-sized container of sweet tea in the walk-in cooler that had been opened and was not labeled with a use-by date. 2. The DS wore a wristwatch on his left wrist while engaged in food preparation in the kitchen. 3. DA C wore a wristwatch on her left wrist while engaged in food preparation in the kitchen. 4. Cook D had facial hair and was not wearing a facial hair restraint while engaged in food preparation in the kitchen. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: 1. Observation on 03/12/2024 at 9:58 AM in the walk-in cooler revealed a gallon-sized container of sweet tea that had been opened and had approximately one pint of tea remaining in the container. The container was not labeled with the date it was opened and a use-by date. During an interview on 03/12/2024 at 10:37 AM the DS stated the container of tea was not labeled with the use-by date and should have been labeled by the staff member storing the container in the cooler. 2. Observation on 03/14/2024 at 10:12 AM in the kitchen revealed the DS wore a wristwatch on his left wrist while engaged in food preparation. The DS removed a pan of meatloaf from the oven, took the temperature of the meatloaf, and returned it to the oven. The DS then wrapped a log of raw beef in plastic wrap for storage. Further observation at 11:55 AM revealed the DS stirred a pot of soup on the stove in the kitchen. 3. Observation on 03/14/2024 at 10:16 AM in the kitchen revealed DA C wore a wristwatch on her left wrist while engaged in food preparation. DA C used a dispenser to fill plastic cups with tea and juice and poured milk from a container before covering the cups with plastic lids. Further observation at 11:45 AM in the kitchen revealed DA C placed food items on trays for the residents' lunch meal. During an interview on 03/14/2024 at 1:25 PM the DS stated he knew both he and DA C should not have worn any jewelry on their wrists while engaged in food preparation in the kitchen. The DS further stated he wanted to help his staff prepare the meal since that day's menu took a while to prepare and he forgot to remove his watch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation on 03/14/2024 at 10:35 AM in the kitchen revealed Cook D had facial hair approximately 1/4 in length on his upper lip. Further observation on 03/13/2024 at 10:40 AM revealed Cook D chopped raw cabbage and cooked the cabbage on a flat top grill for the lunch meal. Cook D did not wear a facial hair restraint. During an interview on 03/14/2024 at 10:36 AM Cook D stated he always had facial hair on his upper lip and was not aware he needed a facial hair restraint. During an interview on 03/14/2024 at 10:36 AM the DS stated Cook D had facial hair on his upper lip and should have worn a facial hair restraint. The DS stated he trained his staff during their orientation to the kitchen upon hire and all staff members had current food handlers certificates. The consultant dietitian conducted inspections during monthly visits but did not provide training to the staff. When asked for policies on dating food for storage, jewelry prohibition in the kitchen, and hair restrains, the DS stated the facility used the TFER as their policy manual and provided a copy of the 2015 edition of the TFER. Record review of the Texas Food Establishment Rules (TFER), October 2015, S228.75(f)(1)(a) revealed, refrigerated, ready-to-eat, time/temperature controlled for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and held at a temperature of 41 degrees Fahrenheit or less if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises .(A) the day the original container is opened in the food establishment shall be counted as Day 1 .(I) A food specified in subsection (g) (1) or (2) of this section shall be discarded if it .(B) is in a container or package that does not bear a date or day, or (C) is appropriately marked with a date or day that exceeds a temperature and time combination as specified in subsection (g) (1) of this subsection. Record review of the Texas Food Establishment Rules (TFER), October 2015, S228.40. revealed, Jewelry Prohibition. Except for a plain ring such as a wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. Record review of the Texas Food Establishment Rules (TFER), October 2015, S228.43. revealed, Hair Restraints. (a) Except as provided in subsection (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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. Commercially prepared food. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed, 2-303.11 Jewelry Prohibition. Except for a plain ring such as a wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, 2-402.11, revealed, (A) Except as provided in (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 5 residents (Resident #17, #253, and #80) reviewed for infection control, in that: 1. Medication Aide G did not utilize appropriate hand hygiene during the medication pass. 2. LVN A did not utilize appropriate hand hygiene during the medication pass. 3. Medication Aide F did not sanitize the wrist blood pressure cuff between resident use. This deficient practice could place residents at risk of infection or transmission of communicable diseases and a decline in health. The findings included: 1. Record review of Resident #17's face sheet, dated 3/15/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included respiratory failure (condition in which the lungs can't get enough oxygen into the blood), type 2 diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), anterior dislocation of right hip (usually caused by a forceful movement of the limb away from the midline of the body with external rotation of the thigh), and angina pectoris (any of a number of disorders in which there is an intense localized pain). Record review of Resident #17's most recent 5-day MDS assessment, dated 2/28/24 revealed the resident was moderately cognitively impaired for daily decision-making skills and received pain medications as needed. Record review of Resident #17's Order Summary Report, dated 3/15/24 revealed the following: - Remove Lidocaine Patch to right hip at bedtime for pain, with order date 3/8/24 and no end date - Lidocaine External Patch 4%, apply to right hip topically one time a day related to anterior dislocation of right hip, remove after 12 hours, with order date 3/8/24 and no end date Observation on 3/14/24 at 8:52 a.m., during the medication pass, revealed Medication Aide G, after administering oral medications to Resident #17, put on a pair of gloves without washing or sanitizing her hands first. Medication Aide G then moved Resident #17's bedside table to one side, took the bed remote to raise the resident's bed, pulled back the resident's blanket, unfastened the resident's incontinent brief, and removed the old Lidocaine patch that was on the resident's right hip. Medication Aide G, while still wearing the same gloves, then applied a new Lidocaine patch to Resident #17's right hip. Medication Aide G, while still wearing the same gloves, then re-fastened Resident #17's incontinent brief, pulled the blanket over the resident, took the bed remote and lowered the bed and adjusted the resident's oxygen nasal canula observed on the resident's face. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/24 at 8:56 a.m., Medication Aide G stated, I should have changed my gloves after touching Resident #17's belongings because it was cross contamination, and the resident could get an infection. 2. Record review of Resident #80's face sheet, dated 3/14/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), muscle wasting, gastroparesis (a condition that affects the stomach muscles and prevents proper stomach emptying), nausea with vomiting, heart failure, gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach [esophagus]), and dysphagia oropharyngeal phase (difficulty swallowing occurring in the mouth and/or the throat). Record review of Resident #80's most recent quarterly MDS assessment, dated 12/20/23 revealed the resident was moderately cognitively impaired for daily decision-making skills and required a feeding tube. Record review of Resident #80's Order Summary Report, dated 3/14/24 revealed the following: - NPO (Nothing by mouth), with order date 12/16/23 and no end date -Enteral Feed Order every shift check g-tube placement and patency prior to each feeding/flushing/medication administration, with order date 12/16/23 and no end date -Enteral Feed Order every shift, flush g-tube with 30-50 ml (milliliters) of water before and after medication administration, with order date 12/16/23 and no end date -Flush peg tube (g-tube) with 180 ml of water every 6 hours, with order date 12/27/23 and no end date Record review of Resident #80's comprehensive care plan, revision date 12/17/23 revealed the resident had a peg tube in place related to a nutritional problem and diabetic gastroparesis and gastroesophageal reflux. Observation during the medication pass on 3/14/24 at 9:12 a.m. revealed LVN A, after cleaning Resident #80's g-tube site with a split sponge soaked in normal saline, removed her gloves, did not wash or sanitize her hands, and put on a new pair of gloves. LVN A then proceeded to continue with g-tube medication administration. During an interview on 3/14/24 at 10:13 a.m., LVN A revealed she was not aware she had not washed or sanitized her hands after putting on gloves. LVN A revealed she should have washed or sanitized her hands between glove changes because it was an infection control issue, and it could cause the resident to get an infection. During an interview on 3/14/24 at 5:18 p.m., the DON stated it was her expectation staff should practice hand hygiene to prevent cross contamination and could cause the resident to get an infection. The DON revealed, it was expected staff should be sanitizing their hands before and after putting on gloves. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #253's face sheet, dated 3/15/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included hyperlipidemia (high cholesterol) and hypertension (high blood pressure). Record review of Resident #253's baseline care plan, dated 3/7/24 revealed the resident had an infection with interventions that included to maintain standard precautions when providing resident care. Observation and interview on 3/14/24 at 4:51 p.m. with Med Aide F revealed he was in the middle of medication pass and was observed retrieving the wrist blood pressure cuff from the medication cart counter to obtain a blood pressure on Resident #253. Med Aide F was not observed sanitizing the wrist blood pressure cuff prior to retrieving it from the medication cart counter. Observation on 3/14/24 at 4:56 p.m., revealed Med Aide F returned to the medication cart, and prepared the medications for Resident #80. Med Aide F then retrieved the same wrist blood pressure cuff used on Resident #253 and obtained Resident #80's blood pressure without sanitizing the wrist blood pressure cuff first. During an interview on 3/14/24 at 5:02 p.m., Med Aide F stated, the wrist blood pressure cuff should have been sanitized after using it on Resident #253 and before using it on Resident #80. Med Aide F revealed, he had forgotten to sanitize the wrist blood pressure cuff because he was nervous, but revealed it was important to sanitize the wrist blood pressure cuff because it was an infection control issue resulting in cross contamination and could result in passing an infection from one resident to the other. During an interview on 3/14/24 at 5:34 p.m., the DON revealed it was her expectation that staff sanitize any blood pressure cuff used between residents to prevent cross contamination. The DON further revealed, if cross contamination had occurred, the resident could get an infection. Record review of the facility policy and procedure titled, Cleaning and Disinfection of Resident Care Items and Equipment, undated, revealed in part, .It is the policy of this facility to maintain clean items and equipment for the residents .Reusable resident items are cleaned and disinfected between residents . Intermediate and low-level disinfectants will be utilized for non-critical items include: stethoscope, blood pressure machines, etc .