STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676303	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirador	5857 Timbergate Dr Corpus Christi, TX 78414

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 Note: The nursing home is disputing this citation.	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** 49157 Based on interviews and record review, the facility failed to consult/ notify the physician when the resident experienced a significant change in their physical status for one (Resident #1) of five residents reviewed for physician notification of changes. The facility failed to consult with/notify the physician after Resident #1 displayed significant changes in condition on [DATE] such as lethargy, vomiting, a decrease of oxygen saturation of 85%, irregular lung sounds and after requiring resuscitation efforts. Resident #1 expired on [DATE]. On [DATE] at 4:45 PM, an immediate jeopardy was identified. While the IJ was removed on [DATE] at 2:35 PM, the facility remained out of compliance at a scope of pattern with a severity of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place residents at risk of a delay in medical treatment, decline in health, and/ or death. Findings included: Record Review of Resident #1's Admission Record revealed an [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included fracture of the ilium (the large bones of the pelvis/ the hip bones), pubis (the bottom part of the hip bones in the center of the pelvis), and the sacrum (the large triangular bone at the base of the spine), falls, atrial fibrillation (irregular heart beat), heart failure, cardiac pacemaker (a small, battery powered device that helps the heart beat in a normal rate and rhythm), and generalized muscle weakness. Record review of Resident #1's Comprehensive MDS dated [DATE] revealed a BIMS score of 14, which indicated that Resident #1 was cognitively intact. Resident #1 required partial/moderate assistance with personal hygiene, bed mobility, laying to sitting, sitting to standing, chair/bed transfer, toilet transfer, and tub/shower transfer. Resident #1 required substantial/ maximal assist with toileting hygiene, showering/ bathing self, upper and lower body dressing and putting on/ taking off shoes. (continued on next page)

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

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record Review of Resident #1's Skilled Nursing Note dated [DATE] at 7:35am indicated Resident #1 was alert and oriented x3 (able to answer at least 3 of the questions usually asked (name, place, time, situation) to assess a person's mental status and orientation), communicated verbally with clear speech, and was able to understand and be understood when speaking. Record review of Resident #1's Care Plan dated [DATE] and [DATE] revealed FOCUS: Resident #1 uses antidepressant medication (Paxil) r/t (related to) Depression initiated on [DATE]. INTERVENTIONS included Monitor/document/report adverse reactions to antidepressant therapy: nausea/vomiting, fatigue, and appetite loss. FOCUS: Resident #1 has congestive heart failure (CHF) initiated on [DATE]. INTERVENTIONS included monitor/document/report any signs/symptoms of congestive heart failure: dry cough, weakness and/ or fatigue, lethargy, and disorientation. FOCUS: Resident #1 has bladder incontinence r/t benign prostatic hypertrophy (enlarged prostate). INTERVENTIONS included Monitor/ document for signs/symptoms of UTI (urinary tract infection): increased temperature and altered mental status. Record review of Resident #1's progress notes revealed the following entries: (All entries created by RN A unless otherwise noted) Health Status Note- Effective: [DATE] at 4:30pm Created: [DATE] at 3:18pm Family member with patient, quite concerned about his lethargy. NP contacted and Paxil order discontinued. Nurse Advanced Skilled Evaluation- Effective: [DATE] at 5:00pm Created: [DATE] at 11:31pm Mental status: Resident #1 is lethargic. Oriented to person. Lethargic: new. Mood and Behavior: Resident#1 has flat affect. Flat affect- Recent change in mood. Nutrition: Decrease in fluid intake noted. Change in appetite noted. No signs or symptoms of possible swallowing disorder. Health Status Note- Effective: [DATE] at 6:00pm Created: [DATE] at 3:22pm This note is a follow up to: [DATE] at 4:30pm Health Status Note Patient's color is now pink. Still lethargic but talking with family member. Taking PO (by mouth) water well. Awaiting supper. Family member remains at bedside. Grips remain strong and equal. Opens eyes better, more vocal. Health Status Note- Effective: [DATE] at 6:36pm Created: [DATE] at 12:37am Family member here at bedside. Concerned about Resident #1s status. SBAR Summary for Providers- Created by LVN D- Effective: [DATE] at 6:49pm Created: [DATE] at 11:31am (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Situation: The change in condition reported on this CIC (change in condition) Evaluation are/were: Altered mental status. At the time of evaluation resident vital signs were Respiratory rate: 24, Temp 100.6. Outcomes of Physical Assessment: Positive findings reported on the resident evaluation of this change in condition were: Mental Status Evaluation: Altered level of consciousness. Functional Status Evaluation: Decreased mobility. Neurological Status Evaluation: Altered level of consciousness. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: What do you recommend Health Status Note- Effective: [DATE] at 7:35pm Created: [DATE] at 11:15pm Called to patient's room. Patient choking on emesis and also coughing up partially digested drink from earlier in the evening. (Not currently eating or drinking anything.) Health Status Note- Effective [DATE] at 7:45pm Created: [DATE] at 3:31pm After briefly returning to the desk, checking texts for phone messages, doctor's recommendation-called directly back to room. Health Status Note- Effective: [DATE] at 7:48pm Created: [DATE] at 3:37pm Patient looking pale, encouraged to deep breathe, and cough. Following commands. Family member concerned, states that she does not want Resident #1 resuscitated if he should need it. States that she has the paperwork in her apartment in IL (Independent Living). Health Status Note- Effective: [DATE] at 7:51pm Created: [DATE] at 11:18pm Patient having difficulty coughing. O2 (oxygen) sat (saturation) drop to 85%. O2 brought into room at , d+[DATE] l/min (liters per minute) via nasal cannula. Suction equipment brought to room. Health Status Note- Effective: [DATE] at 7:56pm Created: [DATE] at 3:46pm Losing all color, suction and respiratory breathing started. Family member remains adamant about not reviving him, however no paperwork reflects this in skilled paperwork. No out of hospital decisions on CPR/ -no code status. Resident #1's status is full code. Still has pain response. CPR started and heart resuscitation started. Pacemaker beats felt. Health Status Note- Effective: [DATE] at 8:00pm Created: [DATE] at 11:19pm CPR in progress. 911 called. Health Status Note- Effective: [DATE] at 8:05pm Created: [DATE] at 11:21pm CPR started by EMS after detecting pacemaker only functioning on patient's own rhythm. Health Status Note- Effective: 050624 at 8:06pm Created: [DATE] at 3:48pm Family member gone to apartment with second family member to obtain paperwork. She told EMS that she did not wish for CPR to be continued. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Health Status Note- Effective: [DATE] at 8:37pm Created: [DATE] at 11:11pm All measures stopped at 8:37pm by EMS team. Last correspondence to the MD about Resident #1's condition was on [DATE] at 6:49pm and stated, Resident #1 had a cough and lethargy. On [DATE] at 6:58pm the MD responded; however the response was not seen by facility staff until after 8:37pm on [DATE]. In an interview with the family member on [DATE] at 10:46am, the family member presented paperwork for Resident #1 that included a Living Will that stated Resident #1 would not want artificially supplied food and water or other life-sustaining procedures should he have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death. Family member presented an Out of Hospital Do Not Resuscitate Form for Resident #1, however it was not filled out or signed. The facility did not have a copy of Resident #1's Living Will and did not have a completed Out of Hospital DNR form. In an interview on [DATE] at 1:43pm, LVN B stated on [DATE], sometime before 8:00pm, she was getting things together for her hall when RN A told her that Resident #1's oxygen saturation was dropping and she was looking for an oxygen concentrator for him. LVN B stated RN A got a portable oxygen cylinder and went back to Resident #1's room. LVN B stated she finished putting stuff in her cart and locked it and went to Resident #1's room. LVN B stated when she walked into the room, RN A was on the opposite side of the bed with the pulse oximeter on Resident #1's hand that was closest to her. LVN B stated that Resident #1's breathing sounded like a boiling pot of water and that RN A told her the oxygen saturation was getting better. LVN B stated she told RN A that they should probably transfer Resident #1 to the hospital because he probably needed more suction than the facility could do. RN A told LVN B to call 911. LVN B stated she went out to the desk to call 911 so she would be able to read his information directly off the computer to the 911 operator. LVN B stated once she got off the phone with 911, she went back into the room to help with Resident #1. LVN B stated when the paramedics arrived, she left the room. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on [DATE] at 2:21pm, RN A stated that on [DATE] at around 4:15 to 4:30pm, Resident #1's family member had told her that she was concerned about him because the last two days (the 5th and 6th) he had been more lethargic than she had noticed before and that he was not responding to her when she talked to him. RN A stated that she went in to check on Resident #1 and he did respond to her. RN A stated Resident #1 had one episode of nausea and vomiting around 5:00pm but then he was ok and drank some water. RN A stated that at about 7:35pm, Resident #1's family member came out to the nurse's station and asked RN A to come into Resident #1's room because she thought he was choking. RN A stated she had no doubt that Resident #1 aspirated because the head of his bed was down and he had vomited. RN A stated she put the head of the bed almost straight up and Resident #1 was projectile vomiting and was coughing. RN A stated at about 7:45pm, she thought that he was just about over it but then he started looking like he was not doing well, and his oxygen saturation was getting low in the 80s, so she went to get some oxygen and checked the message from the MD. RN A stated she did not take the phone with her back to the room. RN A stated that LVN B came into the room with the suction and crash cart. At approximately 8:00pm, LVN B went out to call 911 from the desk phone then went back into the room to help with CPR (Cardiopulmonary resuscitation). RN A stated the paramedics arrived at about 8:05pm and continued CPR and Resident #1's family members went to the wife's apartment on the independent living side of the facility to get Resident #1's DNR (Do not resuscitate) paperwork. The paramedics were on the phone with medical control (a physician at a local emergency room that will give the paramedics at the scene specific orders for treatment if/ when necessary) while doing CPR on Resident #1. RN A stated that the paramedics stopped doing CPR and pronounced Resident #1 deceased at approximately 8:37pm at the direction of Medical Control. RN A stated the paramedics then left and she cleaned up the resident for the family. RN A stated she contacted the NP prior to 5:00pm about Resident #1's lethargy and first episode of vomiting and the NP discontinued the Paxil. RN A stated she texted the NP after 5:00p because she wanted to get lab and x ray orders because of Resident #1's fever but did not get an answer so she the texted the MD from the work phone. RN A stated the MD's answer was, What do you recommend, but that she did not see that until after the code at 8:37pm. RN A stated that she stated in her text to the MD that Resident #1 had had an episode of nausea and vomiting and that he had a low grade fever for two days on her shift and requested some lab work or x rays. RN A stated she was surprised when the MD texted back with, what do you recommend. RN A stated she did not try to call the MD because she did not have the phone with her. RN A also stated she did not direct LVN B to contact the physician because LVN B was busy with contacting 911 then with helping with Resident #1. In a phone interview on [DATE] at 4:11pm, the MD stated that he had gotten a text message from the facility on [DATE] at 6:49pm that said, Resident #1 has cough and lethargy'. The MD stated he texted back and asked, what do you recommend? hoping that the facility would give him some more information because the first text was very vague. The MD stated the next text he received was at 8:43pm and stated, Resident #1 suddenly aspirated and 911 was called. The MD stated he then received a text at 8:45pm that said, Resident #1 was coded for 37 minutes and deceased . The MD stated the next and final text message he received at 9:37pm stated, ER (emergency room) stopped CPR at 8:37pm. The MD stated that he did not understand the aspiration because he was not aware and had not been told that Resident #1 had been vomiting. The MD stated that was the only communication he received from the facility and that he did not see a missed call from the facility before the first text message at 6:49pm. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In a phone interview on [DATE] at 9:14am, the MD stated in this situation, he would have expected to be contacted when the resident was looking worse and about Resident #1 being a full code and the family member not wanting CPR done. The MD also stated he would expect the facility to contact the NP or on call person as soon as there had been a change in Resident #1's condition. The MD stated if the NP or on call person was unavailable, the facility should have contacted him directly after Resident #1 aspirated and his condition was worsening. The MD stated if he had the information that was initially sent to the NP on Resident #1's condition, he would have asked for labs, and asked further questions as more information would have been needed at that time. The MD further stated if the facility had contacted as soon as Resident #1 aspirated, he would have had him sent to the emergency room immediately to be treated. The MD stated he was not certain that sending Resident #1 to the emergency room would have had a different outcome, but it was possible. In an interview on [DATE] at 5:15pm, the DON stated that she had taken a picture or screen shot of the text messages from the facility phone from [DATE] and had them on her phone. The DON read the text messages with times and content out loud to this state surveyor but did not allow visual confirmation. The following was what was read: 5:12pm the NP was notified about Resident #1's lethargy, that he had been started on Paxil a week ago, and the family wants to discontinue it. Also, Resident #1 running low grade temp. Flu and COVID negative. 5:22pm the NP texted back, Yes, that's fine. 5:46pm text to NP, Update temp of 100.6, has had cough. Incontinent, not new, has several wounds that require care, not particularly new. 5:48pm text to NP, Do you want labs or x ray done? (There was no response from the NP to the 5:46pm or 5:48pm texts) The DON stated, there was possibly an unanswered phone call placed to the MD, between 5:48pm and the next text that was sent. 6:49pm text to MD, Resident #1 has cough and lethargy. 6:59pm response text from MD, what do you recommend? (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	12:59 PM - CNA O 1:04 PM - CNA P All unlicensed staff interviewed stated if a resident had an emergent situation, they would pull the call light to get a nurse and check for a pulse. The charge nurse would go in and take charge and delegate tasks to the assisting staff. All staff stated they had participated in a mock code drill. Verification of Plan of Removal on [DATE] revealed: 1. Record review of all resident's code status who were at risk for being affected by the same deficient practice was conducted. Record review of audits that were conducted to identify residents with advanced directives specifically residents who had DNR orders versus full code orders. A binder was created to easily identify these residents in the event of an emergency. Record review of the code status binder was reviewed which have been placed at the nurse's stations. 2. Through interviews and record review, the Director of Nurses was educated by the Administrator on the facility Policy and Procedure for Notification of Changes to the Physician including the When to Call and Care Pathways resources. The remaining Facility Nursing staff was interviewed on the educated conducted by the Director of Nurses/Designee on the Policy and Procedure for Notification of Changes to the Physician. Through interviews nursing staff employees who could not be contacted was immediately removed from the schedule until they were trained on the policies and procedures for Notification of Changes, and when to call the physician. 3. Record review of in-services was of the Mock Code Drills, of various shifts was conducted. Through interviews, A Mock Code Drill will occur once on each shift the first week ([DATE] through [DATE]) for a total of three drills, and then once weekly on one of the three shifts for three weeks. After this, a Mock Code Drill will be conducted on a random shift once monthly every month. These drills will be documented on the attached form and filed in the Mock Code Drill Log. The Mock Code Drills will be conducted by the Director of Nurses/Designee. Interviews were conducted with staff members on various shifts on the Mock Code Drill and all staff members were able to identify the procedures put into place if a resident were to code. Record review of the Mock Code Drill binder was conducted. In an interview on [DATE] at 12:00pm, the Administrator stated that in-service began on [DATE] with staff and no staff were allowed back on the floor until training on resident change of condition/SBAR, preferred MD notification which was by phone and not through text and staff have conducted a mock code drill which was conducted yesterday and another one was scheduled for [DATE]. The administrator stated that if a nurse has placed a call to the physician, then that nurse was to keep the phone on them until physician contacts that nurse back with directions. The Administrator stated that the Mock Drill binder would be kept by nursing administration/IDT (Interdisciplinary Team) and a mock code drill would be conducted and reviewed monthly after the second mock code drill was conducted. The Administrator stated if concerns were identified it would be discussed immediately and addressed as it would become part of the QAPI meeting discussions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676303	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirador	5857 Timbergate Dr Corpus Christi, TX 78414

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Administrator was informed the Immediate Jeopardy (IJ) was removed on [DATE] at 2:35 PM. The facility remained out of compliance at a scope of pattern with a severity of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47371 Based on observation, interview, and record review, the facility failed to respect the resident's right to personal privacy and confidentiality of his or her personal and medical records for four (Residents #1, Resident #2, Resident #3, and Resident #4) of four Residents reviewed for privacy issues, in that: 1. RN A did not lock her electronic health record computer screen on 07/06/2024, exposing Resident #1, Resident #2, Resident #3, and Resident #4's medical records to the community residents and visitors. This failure could place residents at risk for embarrassment, poor self-esteem, and unmet needs. The findings included: Record review of Resident #1's Face Sheet dated 07/06/2024, initially admitted on [DATE], and readmitted on [DATE] documented an [AGE] year-old female with the following diagnoses of: cerebral infarction (stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness) and vascular dementia (cognition impairment) Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 06-meaning a severe cognitive impairment and was substantially reliant of on staff for all ADLs. Record review of Resident #2's Face Sheet dated 07/06/2024, initially admitted on [DATE], and readmitted on [DATE] documented an [AGE] year-old female with the following diagnoses of: acute respiratory failure (breathing failure), heart failure, and dyspnea (shortness of breath). Record review of Resident #2's Quarterly MDS dated [DATE] revealed Resident #2 had a BIMS score of 15-meaning cognitively aware and was dependent/substantially reliant of on staff for all ADLs. Record review of Resident #3's Face Sheet dated 07/06/2024, initially admitted on [DATE], and readmitted on [DATE] documented an [AGE] year-old male with the following diagnoses of: Alzheimer's disease (cognitive impairment), and dementia (cognition impairment). Record review of Resident #3's Quarterly MDS dated [DATE] revealed Resident #3 had a BIMS score left blank indicating unable to complete interview and was dependent of on staff for all ADLs. Record review of Resident #4's Face Sheet dated 07/06/2024, initially admitted on [DATE], and readmitted on [DATE] documented an [AGE] year-old female with the following diagnoses of: Alzheimer's disease (cognitive impairment), and chronic obstructive pulmonary disease (constricted airway making breathing difficult). Record review of Resident #4's Quarterly MDS dated [DATE] revealed Resident #4 had a BIMS score of 03-meaning a severe cognitive impairment and was substantially reliant of on staff for all ADLs. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/06/2024 at 3:33PM upon initial observation into the SNF unit, there were multiple clinicals staff members near the nursing station. RN A was positioned in front of a mobile cart with computer screen displaying residents' pictures and names. RN A then vacated her mobile medication cart leaving her computer screen easily visible and accessible. Upon further inspection the computer screen displayed Resident #1, Resident #2, Resident #3 and Resident #4's names, pictures with distinctive yellow background coloration which was initially visible from approximately 10 feet away. Further inspection of screen revealed what Resident #1, Resident #2, Resident #3 and Resident #4 looked like, their name, with immediate accessibility to click onto any resident's profile to access multiple residents' confidential information, including name, date of birth, primary physician, and health related documentation. The name of the intended user of the computer was RN A. During an interview on 07/06/2024 at 3:43PM MA A stated when you login to the electronic health record you have a blank login screen, once logged in pictures of all residents will be seen. MA A stated it is necessary to lock the electronic health record screen to hide pictures and room numbers of all residents so that no non-staff member will have access to private and confidential resident information. MA A stated locking the electronic health record screen when leaving are preventative measures to protect all resident's privacy. MA A stated privacy is important to keep everyone records confidential. MA A stated no non-staff member person should be able to see resident screen information. MA A stated if a non-staff member person had access to every resident's medical file, they could access a resident's medication list, diagnosis, nurse's notes, name, date of birth, or vitals, which would compromise a resident's right to privacy. MA A stated a resident could wish for no one to know they were living at the facility, and if the nurse's computer screen was not locked, a non-staff person could recognize the electronic health record picture and spread the information compromising a resident's right to privacy which could make the resident feel embarrassed. MA A was presented a photograph of an unlocked computer screen that displayed pictures and names, with a yellow background. MA A responded to the picture by stating it was a picture of an unlocked electronic health record screen, which displayed multiple residents name and date of birth. During an interview on 07/06/2024 at 3:51PM, RN A stated she accidentally left her computer screen unlocked with she was notified that a resident was requesting medication for pain. RN A stated she forgot to close/lock the screen lock but should have locked the screen to keep non-staff members from having access to resident confidential medical records. RN A stated non-staff members should not be able to see names and pictures of resident because that is a part of confidential medical records and could attain sensitive information. RN A stated she will ensure to be more cognitively aware of ensuring residents right to privacy. RN A stated if a non-staff member were to attain residents' confidential information it could affect them negatively and could infringe on HIPPA regulations to protect a resident's right to privacy. During an interview on 07/06/2024 at 6:00PM the Administrator stated when asked if a resident's information should be accessible to people who are non-staff members, he stated it depends. The Administrator stated when asked would a resident's name, date of birth, primary physician, vital signs be considered information that would be considered confidential information, the Administrator stated if it fell under the definition on the facility's Residents Rights policy, then it would. The Administrator stated, when asked, does resident information fall under the definition of confidential information, no definitive answer was given, and was referred to review the facility's policy regarding Resident's Rights. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Resident Rights policy revised dated February 2021, revealed, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; t. privacy and confidentiality;