STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676308	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Rehabilitation and Care Center	4100 College Park Dr Round Rock, TX 78665

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs for 2 of 6 residents (Resident #8, and Resident #38) reviewed for accommodation of needs. The facility failed to ensure Resident #8 and Resident #38's call lights were placed within their reach. This failure could place dependent residents at risk of injuries and unmet needs. Findings included: Resident #8 Review of Resident #8's undated face sheet reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] with diagnosis of Cerebral infarction (stroke), Muscle weakness, Moderate protein-calorie malnutrition, History of falling, and chronic pain. Review of Resident #8's Quarterly MDS Assessment, dated 03/15/24, reflected she had a BIMS score of 2 indicating she was severely cognitively impaired. Section GG (Functional Abilities and Goals) of the same MDS indicated Resident #8 was Substantial /Maximal assistance with ADL care such as toileting, dressing, and personal hygiene. Section GG also indicated Resident #8 had impaired mobility on 1 side that interfered with daily functions or placed resident at risk of injury. Record review of Resident #8's care plan dated 11/10/23 and revised 5/27/24 reflected Resident #8 had a risk for falling related to Hemiplegia (paralysis) to the left side. The approach on the risk for falling care plan was to keep the call light in reach at all times. In an observation on 05/28/24 at 10:35 AM, the door to Resident'#8's room door was shut and upon entry she was lying in bed with her eyes closed. Resident #8 was not able to be interviewed. The bed was in the highest position from the floor and side rails were observed in place on the bed in a raised position. Resident #8's call light was tucked under the mattress on the left top side of the bed. Resident #38 (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #38's undated face sheet reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] with diagnosis of Dementia (impaired ability to remember), Unspecified fracture of the right femur, Muscle weakness, and urgency of urination. Review of Resident #38's Quarterly MDS Assessment, dated 03/15/24, reflected she had a BIMS score of 4 indicating she was cognitively impaired. Section GG (Functional Abilities and Goals) of the same MDS indicated Resident #38 was Partial / Moderate assistance with ADL care such as toileting, dressing, and personal hygiene. Record review of Resident #38's care plan dated 10/16/22 and revised 05/27/24 reflected Resident #39 was at risk for falling related to impaired mobility and impaired cognition. The approach on the risk for falling care plan was to keep the call light in reach at all times. In an observation and interview on 05/28/24 at 10:15 AM, Resident #38's call light was tied to the right side of bed rail. The bed rail was in the low position and the call light was on floor. Resident #38 was asked if she could reach her call light and she was unable to reach it. She said sometimes she just yells for help. In an interview and observation on 05/28/24 at 10:40 AM, LVN A stated call lights should always be in residents reach. She stated everyone is responsible for ensuring call lights are within residents reach. She stated the staff ensure this by making rounds and checking on the residents. LVN A stated the risk for the resident for not having their call light within reach would be the resident would not be able to call for assistance. LVN A states she just came onto shift and was not aware that the call lights were out of reach. LVN A was observed instructing the CNAs to make a round and check call lights to make sure they were within the residents reach for all residents. In an interview on 05/28/24 at 10:45 AM, CNA A stated the call lights should always be in reach of the resident. She stated normally CNAs make observations on each resident checking to ensure lights are within reach every 2 hours. CNA A stated its everyone's responsibility to ensure call lights are in reach. She stated the risk to the resident is that they would not have their needs met. In an interview with the ADM on 05/30/24 at 01:21 PM, she stated call lights should be placed within resident reach. CNAs are expected to make rounds and ensure call lights are within reach for each resident. Everyone is responsible for call lights. The ADM stated the negative outcome for residents would be that they cannot make their needs known. She stated staff were educated in In-Services on having call lights within reach of residents. Record review of facility policy titled Call lights, responding to dated May 5,2023 procedure #6 reflected when leaving the patients or residents room ensure the call light is placed within the patients/residents reach.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observation, interview and record review the facility failed to ensure residents were free from physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 6 residents (Resident #8) reviewed for freedom from physical restraints. The facility failed to obtain a physician's order, code the MDS, and care plan Resident #8's bed rails in which the resident movements were restricted and there was no documentation the restraints were required to treat her medical symptoms. This failure could put residents at risk of unnecessary restriction of their freedom of movement (any change in place or position for the body or any part of the body that the person is physically able to control). Findings included: Review of Resident #8's undated face sheet reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] with diagnosis of Cerebral infarction (stroke), Muscle weakness, Moderate protein-calorie malnutrition, History of falling, and chronic pain. Review of Resident #8's Quarterly MDS Assessment, dated 03/15/24, reflected she had a BIMS score of 2 indicating she was severely cognitively impaired. Section GG (Functional Abilities and Goals) of the same MDS indicated Resident #8 was Substantial /Maximal assistance with ADL care such as toileting, dressing, and personal hygiene. Section GG also indicated Resident #8 had impaired mobility on 1 side that interfered with daily functions or placed resident at risk of injury. The MDS did not reflect the use of bed rails used on bed in section P. Record review of Restraints/Adaptive Equipment - Siderail Review and Consent dated 03/16/2024 reflected Resident #8 did not have a diagnosis or medical condition for which the use of side rails was being considered area was marked as n/a. Resident #8 did not have a functional need for the use of side rails. Resident #8 did not have the ability to raise and lower the side rails. The review reflected the only other alternative tried prior to using side rails was to have the call bell in reach. The reason for use of side/bed rails was left unmarked. Record review of Resident #8's care plan dated 11/10/23 and revised 5/27/24 reflected Resident #8 had a risk for falling related to Hemiplegia (paralysis) to the left side. The care plan did not include the use of side/bed rails or a restraint. In an observation on 05/28/24 at 10:35 AM, the door to Resident #8's room was shut and upon entry she was lying in bed with her eyes closed. Resident #8 was not able to be interviewed. Her bed was in the highest position from the floor and side/bed rails were observed in place on the bed in a fully raised position. Resident #8's call light was tucked under the mattress on the left top side of the bed. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 05/28/24 at 10:40 AM, LVN A stated she just came onto shift and was not aware that the call lights were out of reach or of the bed in the elevated position. LVN A was observed instructing the CNAs to make a round and check all beds and call lights to make sure the beds were in low position and call lights were within the residents reach for all residents. In an interview with MDS B on 05/30/24 at 11:48 AM, she stated she had worked at the facility for [AGE] years. She stated the facility did not use restraints. She stated side rails were used as a mobility enhancer. She stated there should have been a care plan and order for the use of side rail. She is responsible for updating the care plan and completing the MDS. The side rails may also be listed on a fall risk care plan or an activities of daily living care plan. She stated Resident#8 is nonmobile. MDS B stated she would expect the nurses to complete their own assessment for side rails. The nurses would then obtain an order from the physician and the MDS nurse would care plan for side rails. She stated recently there was an audit competed on side rails and the facility had discontinued Resident #8s side rails and this is why the care plan and order were not in place. In an interview on 05/30/24 at 1:10 PM, the DON stated orders should be obtained for side rails. The floor nurses are responsible for obtaining orders. The floor nurses' complete quarterly assessments for side rails to ensure safety and appropriateness. If the nurse at that time sees a resident that has inappropriate side rails the nurse would notify doctor to discontinue use of the side rails. The facility maintenance man would then remove side rails from the bed. The DON stated if a resident used side rails, she would expect the MDS nurse to code side rails on the MDS if there was no indication that they are used as a mobility enhancer. Side Rails should have been care planned. usually under falls, mobility, or activities of daily living. She stated she did not see how a side rail, or this error would hurt Resident #8 in any way. She stated yes if side rails were used and were not clarified as a mobility device then it should be coded on the MDS, and care planned. In an interview on 05/30/24 at 1:21 PM, the ADM stated the facility did do a recent evaluation and interdisciplinary team meeting on side rails. She stated she believed Resident #8 may have just fallen through the cracks. The ADM stated it was the goal of the facility to have minimum side rails unless they are ordered and necessary. She stated she believed the facility was trying to do the right thing by trying to get rid of side rails. A record review of facility policy titled Restraints dated May 5, 2023, reflected: The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Definition: A physical restraint is any manual method, or physical, or mechanical device material or equipment attached or adjacent to a patient/resident's body that the individual cannot remove easily, and which restricts freedom of movement or normal access to one's body. 3. The use of side rails as a restraint is prohibited. Side rails are only used when necessary to treat the patient/resident's medical symptoms. Side rails can be used for physical function but only after assessment and should be considered as a last resort. 4. The physician's order for restraints should reflect the presence of a qualifying medical symptom. 5. Update care plan with the problem, goal, and approaches, which must include: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Observation e. Release f. Repositioning, at least every 2 hours Ongoing restraint use: The Plan of Care should be updated at least quarterly and with any significant change, including the medical symptoms which continue to warrant the need for a restraint.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 50042 Based on observation, interview, and record review the facility failed to ensure assessments accurately reflected the resident's status for two (2) (Resident #8 and Resident #77) of six (6) residents reviewed for assessments. The facility failed to ensure the MDS (Minimum Data Set) assessment accurately reflected: Resident #8 was using bed rails daily. Resident #77's diagnosis of dementia (a group of symptoms affecting memory, thinking, and social abilities) was coded as a psychotic disorder (condition of the mind) on the MDS assessment. This deficient practice could have placed the resident at risk for inadequate care due to inaccurate assessments. Findings included: Resident #8 Review of Resident #8's undated face sheet reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] with diagnosis of Cerebral infarction (stroke), Muscle weakness, Moderate protein-calorie malnutrition, History of falling, and chronic pain. Review of Resident #8's Quarterly MDS Assessment, dated 03/15/24, reflected she had a BIMS score of 2 indicating she was severely cognitively impaired. Section GG (Functional Abilities and Goals) of the same MDS indicated Resident #8 was Substantial /Maximal assistance with ADL care such as toileting, dressing, and personal hygiene. Section GG also indicated Resident #8 had impaired mobility on 1 side that interfered with daily functions or placed resident at risk of injury. The MDS did not reflect the use of bed rails used on bed in section P. Record review of Restraints/Adaptive Equipment - Siderail Review and Consent dated 03/16/2024 reflected Resident #8 did not have a diagnosis or medical condition for which the use of side rails was being considered area was marked as n/a. Resident #8 did not have a functional need for the use of side rails. Resident #8 did not have the ability to raise and lower the side rails. She was total dependence for bed mobility and had no fall history. The review reflected the only other alternative tried prior to using side rails was to have the call bell in reach. The reason for use of side/bed rails was left unmarked. Record review of Resident #8's care plan dated 11/10/23 did not include the use of side/bed rails or a restraint. In an observation on 05/28/24 at 10:35 AM, the door to Resident #8's room was shut and upon entry. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She was lying in bed with her eyes closed. Resident #8 was not able to be interviewed. Her bed was in the highest position from the floor and side/bed rails were observed in place on the bed in a raised position. Resident #8's call light was tucked under the mattress on the left top side of the bed. In an interview with MDS B on 05/30/24 at 11:48 AM, she stated she had worked at the facility for [AGE] years. She stated the facility did not use restraints. She stated side rails were used as a mobility enhancer. She is responsible for updating the care plan and completing the MDS. MDS B stated she would expect the nurses to complete their own assessment for side rails. The nurses would then obtain an order from the physician and the MDS nurse would care plan for side rails. She stated recently there was an audit competed on side rails and the facility had discontinued Resident #8s side rails. In an interview on 05/30/24 at 1:10 PM, the DON stated if the nurse at that time sees a resident that has inappropriate side rails the nurse would notify doctor to discontinue use of the side rails. The facility maintenance man would then remove side rails from the bed. The DON stated if a resident used side rails, she would expect the MDS nurse to code side rails on the MDS if there were no indications that they are used as a mobility enhancer. She stated she did not see how a side rail, or this error would have any negative effects on Resident #8 in any way. In an interview on 05/30/24 at 1:21 PM, the ADM she stated the facility did do a recent evaluation and interdisciplinary team meeting on side rails. She stated she believed Resident #8 may have just fallen through the cracks. The ADM stated it was the goal of the facility to have minimum side rails unless they are ordered and necessary. She stated she believed the facility was trying to do the right thing by trying to get rid of side rails. Resident #77 Record review of Resident #77's undated face sheet, reflected diagnosis of Venous insufficiency (lacking blood flow to extremities), Cellulitis of left lower limb (infection of the skin), Dry eye syndrome of bilateral lacrimal glands, Localized edema (swelling), Delusional disorders, Insomnia (inability to sleep), unspecified, Moderate protein-calorie malnutrition, Deficiency of other vitamins, Nutritional deficiency, unspecified, Unspecified dementia (impaired memory), unspecified severity, with agitation. Record review of Resident #77's care plan dated 03/04/24 and updated 05/20/24 included a category of Cognitive loss related to the diagnosis of Dementia. Record review of form 1012, Mental Illness/Dementia Resident Review, for Resident #77, completed on 3/20/2024, section B states, Dementia Defined a neurologically driven disease that results in a decline in mental ability severe enough to interfere with independence and daily life. Neither dementia nor psychosis or depression related to dementia is a mental illness. Which was answered, Yes, the individual has a primary diagnosis of dementia as defined above. Record review of Resident #77's quarterly MDS dated [DATE], reflected Neurological diagnosis Section I4800 (active diagnosis of dementia) was not marked. Psychiatric/Mood Disorder I5950, psychotic disorder (other than schizophrenia) was marked. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempts to interview Resident #77 on 5/28/24 at 10 AM were unsuccessful. Resident #77 was confused. Resident was observed dressed and groomed sitting in his room. In an interview with MDS A on 5/30/24 at 1:40 PM, she stated that Resident #77 was classified as having a psychotic disorder as his progress notes show that he had a diagnosis of dementia with psychotic features. Interviewed on 5/30/34 at 1:49 PM,the DON said dementia could be considered either a psychotic or neurological disorder. The DON said that some say dementia with psychotic disturbances could be classified as a psychotic disorder. The DON said she really was not sure though because she is not a MDS Coordinator. When asked what negative effects could result if a MDS was not coded correctly, the DON stated that miscoding would not hurt the resident; the only negative effect would be the payment differential to her knowledge. Interview on 5/30/24 at 2:10 PM, MDS A said regarding the possible MDS discrepancy related to Resident #77's psychotic disorder designation. MDS A disagreed that any MDS discrepancy occurred or existed, but she completed form 1012 out of due diligence. MDS A stated that resident #77 had a primary diagnosis of dementia with psychotic features noted somewhere in his record. MDS A said the resident's progress note says dementia with psychotic features. Interview on 5/30/24 at 2:15 PM,. MDS B said she had been a MDS Coordinator for one year. MDS B said she is not sure she would have classified Resident #77 as having a psychotic disorder. MDS B said she would have checked with their Regional MDS Consultant. MDS B provided the name and contact information for their Regional MDS Consultant. In an interview on 5/30/24 at 2:39 PM, the Regional MDS Consultant via telephone. The Regional MDS Consultant stated that she believed Resident #77's MDS assessment is correct. She stated that she stands behind MDS A's indication that Resident #77 has a psychotic disorder due to progress notes which state the resident has dementia with psychosis and dementia with psychotic features. The Regional MDS Consultant stated that the completion of form 1012 was appropriate, especially if the MDS Nurse hadn't dug through the record completely and wanted an endorsement. In a record review of facility policy titled MDS Primary Assessments dated 5/5/23 and revised 9/28/2023 The MDS is completed according to the Resident Assessment Instrument (RAI) Guidelines. Record review of facilities Resident Assessment Instrument Guidelines for P0100 Physical Restraints defines physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Bed rails include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom.). Include in this category enclosed bed systems. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both.) meets the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A. Record review of Resident Assessment Instrument Guidelines for Active Diagnosis section I of the MDS reflected Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. The RAI further classifies Dementia as a neurological disorder under section I4800.

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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** 41654 Based on observation, interview and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission for 2 (Resident's # 88 and #90) of 3 residents reviewed for baseline care plans. The facility failed to develop baseline care plans within the required 48-hour timeframe for Resident's #88 and #90. This failure could place residents at risk for not receiving necessary care and services or having important care needs identified and met. Findings included: Review of Resident #88's face sheet dated 05/30/24 reflected Resident #88 was a [AGE] year-old male admitted on [DATE] with diagnoses including acute kidney failure (a sudden decrease in kidney function that develops within 7 days), cerebral infarction (pathologic process that results in an area of necrotic tissue in the brain), hypertension (high blood pressure), and diabetes (a group of diseases that result in too much sugar in the blood). Review of the admission MDS dated [DATE] reflected Resident #88 had not been interviewed for a BIMS score and there was no indication of the residents level of cognition. Review of Resident #88's clinical record dated on 05/30/24 reflected a baseline care plan was not completed in the 48-hour timeframe. Review of Resident #88's comprehensive care plan dated 11/15/23 from the prior stay in facility revealed Resident #88 had unclear speech r/t CVA. Required extra time to make needs known. Resident #88 was at risk for being misunderstood. Goal: Resident will make self-understood. Approach: Observe for non-verbal signs of distress (guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc.). Turn/reposition, communicate with/touch, provide peri care, assess for pain, provide liquids/food as needed. Review of Resident #90's face sheet dated 05/30/24 reflected Resident #90 was a [AGE] year-old male admitted on [DATE] with diagnoses including cellulitis of buttock (a skin infection that can affect the buttocks, legs, and head), hypertension (high blood pressure), congestive heart failure (when your heart cannot pump enough blood to provide your body with the blood and oxygen it needs) and paraplegia (paralysis of the legs and lower body, typically caused by injury or disease). Review of the admission MDS dated [DATE] reflected Resident #90 had a BIMS score of 15 indicating Resident #90 was not cognitively impaired. Review of Resident #90's clinical record dated 05/30/24 reflected a baseline care plan was not completed in the 48-hour timeframe. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #90's comprehensive care plan dated 02/27/24 revealed Resident #90 had required assistance with ADL's. Goal: Resident would maintain a sense of dignity by being clean, dry, odor free and well-groomed over the next 90 days. Approach: Transferred with one to two person assist. In an interview on 05/30/24 at 9:36 AM, the ADM stated there were no baseline care plan completed for Resident's #88 and #90. She stated the facility had their baseline care plan process in place, but she was not sure why those two were not completed by the admitting charge nurse. In an interview on 05/30/24 at 9:47 AM, the DON stated the charge nurses was responsible for completing the baseline care plan's when a resident is admitted to the facility. She stated baseline care plans were to be completed within 48 hours of a resident admitting to the facility. She stated the MDS nurses were to check the new admissions to ensure the baseline care plans were completed and if the MDS nurses found that a baseline care plan was not completed, they would write it on the communication board, and it would be reviewed in the morning meeting. She stated the information would have been given to the nurse which should have completed the baseline care plan to complete. She stated she was not sure why those care plan's had not been completed. She stated the MDS nurse's had been trained on ensuring the baseline care plans were completed. She stated if a resident's care plan was not completed correctly, the resident's correct information may not be given to the nurse if the needed it to care for the resident's. She stated that was what the care plans were for. In an interview on 05/30/24 at 10:25 AM, the ADM stated baseline care plans were done by the charge nurses and the MDS nurses were responsible for the chart reviews. She stated if there was a missing baseline care plan, the MDS nurses would write it on the communication board for the clinical meeting that was held each morning to go over. She stated the MDS nurses completed the comprehensive care plans. She stated she was not sure what happened in those particular situations with those baseline care plans for Resident's #88 and #90. She stated those baseline care plans should have been completed. She stated the MDS nurses are responsible for chart checks and have been trained on checking for accuracy of charts and to make sure the baseline care plans were done. She stated the MDS nurses were trained to write the information on the communication board and were to inform the nurses if a baseline care plan was not completed. She stated if a base line care plan was not completed staff may not know the summary of a residents care. She stated she does not feel like a residents care would have been affected if a baseline care plan had not been completed. In an interview on 05/30/24 at 12:22 PM, MDS A stated the nurses were responsible for completing the baseline care plans and she did the comprehensive care plans. She stated she checked the charts to make sure the baseline care plans were done. She stated they had a nurses meeting every morning and after she checked the charts, she would put any issues on the information board in the meeting room for the nurses to follow through. She stated in reference to the baseline care plans for Resident's #88 and 90, there were new nurses working and neither of them completed the baseline care plans. She stated when she found that there was no care plan for those residents, she educated the nurses on completing the baseline care plans. She stated baseline care plans were to be completed within 48 hours of admission. She stated she did not feel like the baseline not being completed would affect the residents care because there is other documentation that the staff would be looking at when a resident admitted , such as a documentation of residents profile which showed any special things residents may have or need, like catheters or transfer requirements, and they also would have hospital records to reflect on. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/30/24 at 12:36 PM, MDS B stated the nurses were responsible for completing the baseline care plans and she did the comprehensive care plans. She stated she checked the charts to make sure the baseline care plans were done. She stated they had a nurses meeting every morning and after she checked the charts, she would put any issues on the information board in the meeting room for the nurses to follow through. She stated in reference to the baseline care plans for Resident's #88 and 90, there were new nurses working and neither of them completed the baseline care plans. She stated when she found that there was no care plan for those residents, she educated the nurses on completing the baseline care plans. She stated baseline care plans were to be completed within 48 hours of admission. She stated if a residents baseline care plan was not completed, nothing could have necessarily happened. She stated staff would follow doctor's orders and ASL's from their admission paperwork and records uploaded in the charts that related to residents, such as hospital records. Record review of the facility policy titled Care Plan Process, Person-Centered Care dated 2023 with a revision date of 05/05/23. The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes trying to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and understanding the resident's life before coming to reside in the nursing home. The facility will provide the resident and their legal representative with a summary of the baseline person-centered care plan that includes but is not limited to the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility any updated information based on the details of the comprehensive person centered care plan, as necessary. The facility will coordinate the development of the person-centered care plan within the required timeframes. Procedures: 1. Develop and implement the baseline person-centered care plan within 48 hours of a resident's admission. 2. The baseline person-centered care plan will include the minimum healthcare information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, resident goals, physician orders, dietary orders, therapy services, social services, and PASARR recommendation, if applicable. 4. Provide the resident and their legal representative (if applicable) a copy of the baseline person-centered care plan summary for the completion date of the comprehensive assessment. Document receipt in the medical record. A. The Baseline Person-centered care plan summary includes immediate resident needs. 11. The person-centered care plan includes: A. Date B. Problem C. Resident goals for admission and desired outcomes D. Time frames for achievement E. Interventions, discipline specific services, and frequency F. Refusal of services and/or treatments 1) Evaluation of resident's decision-making capacity 2) Educational attempts 3) Attempts to find alternative means to address the identified risk/need G. Discharge plans 1) Resident's preference and potential for future discharge 2) Resident's desire to return to the community and any referrals to local contact agencies and/or other appropriate entities, for this purpose H. Resolution/Goal Analysis.

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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** 47772 Based on observation, interview and record review, the facility failed to develop a comprehensive care plan, as well as implement a comprehensive care plan, to meet the medical and nursing needs and the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being of 2 (Resident #8 and Resident #60) of 15 residents reviewed for care plans. 1)The facility failed to complete an accurate comprehensive care plan for Resident #8 by not including side rails. 2) a. The facility failed to provide Resident #60 with a functioning communication system to call for nursing assistance. b. The facility failed to provide Resident #60 with a comprehensive care plan having addressed her functional limitations to utilize the facility's call light system and having developed alternative approaches and interventions for care. These failures placed residents at risk of not having their care and treatment needs assessed to ensure necessary care and services were provided. Resident #8 Review of Resident #8's undated face sheet reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of Cerebral infarction (stroke), Muscle weakness, Moderate protein-calorie malnutrition, History of falling, and chronic pain. Review of Resident #8's Quarterly MDS Assessment, dated 03/15/24, reflected she had a BIMS score of 2. A BIMS Score of 2 indicated Resident #8 had severe cognitive impairment. Section GG (Functional Abilities and Goals) of the same MDS indicated Resident #8 was Substantial /Maximal assistance with ADL care such as toileting, dressing, and personal hygiene. Section GG also indicated Resident #8 had impaired mobility on 1 side that interfered with daily functions or placed resident at risk of injury. Record review of Resident #8's care plan dated 11/10/23 and revised 5/27/24 reflected Resident #8 had a risk for falling related to Hemiplegia (paralysis) to the left side. The care plan did not indicate a need for Resident #8 to have side rails. In an observation on 05/28/24 at 10:35 AM, the door to Resident #8's room was shut and upon entry (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was lying in bed with her eyes closed. Resident #8 was not able to be interviewed. Her bed was in the highest position from the floor and side rails were observed in place on the bed in a raised position. Resident #8's call light was tucked under the mattress on the left top side of the bed. In an interview with MDS B on 05/30/24 at 11:48 AM, she stated she had worked at the facility for [AGE] years. She stated there should have been a care plan for the use of side rail. She is responsible for updating the care plan. The side rails may also be listed on a fall risk care plan or an activities of daily living care plan. MDS B stated she would expect the nurses to complete their own assessment. The nurses would then obtain an order from the physician and the MDS nurse would care plan for side rails. She stated recently there was an audit competed on side rails and the facility had discontinued Resident #8s side rails and this was why the care plan was not in place. In an interview on 05/30/24 at 1:10 PM, the DON stated orders are to be obtained for side rails. The floor nurses are responsible for obtaining orders. The floor nurses' complete quarterly assessments for side rails to ensure safety and appropriateness. If the nurse at that time sees a resident that has inappropriate side rails the nurse would notify doctor to discontinue use of the side rails. The facility maintenance man would then remove side rails from the bed. The DON stated if a resident used side rails, she would expect the MDS nurse to code side rails on the MDS, it should be care planned, usually under falls, mobility, or activities of daily living. She stated she did not see how a side rail, or this error would hurt Resident #8 in any way. She stated yes if side rails were used and were not clarified as a mobility device then it should be coded on the MDS, and care planned. In an interview on 05/30/24 at 1:21 PM, the ADM stated the facility did do a recent evaluation and interdisciplinary team meeting on side rails. She stated she believed Resident #8 may have just fallen through the cracks. The ADM stated it was the goal of the facility to have minimum side rails unless they are ordered and necessary. She stated she believed the facility was trying to do the right thing by trying to get rid of side rails. Resident #60 Record review of Resident #60's Quarterly MDS, dated [DATE], Section A., Identification: Indicated the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Section C., Cognitive Patterns: Indicated the resident's cognitive function was severely impaired. Section I., Active Diagnoses: Indicated the resident was diagnosed with Aphasia (which was a comprehension and communication disorder having resulted from damage or injury to the brain,) Hemiplegia (which caused one-sided paralysis,) Cerebral Vascular Accident (which was a condition that caused an interruption of blood flow to the brain,) and Seizure Disorder (which was a sudden alteration of behavior due to a temporary change in the electrical functioning of the brain.) Section GG., Functional Abilities and Goals: Indicated the resident had impairment with both upper extremities (shoulder, elbow, wrist, and hand.) Resident utilized a wheelchair for mobility. Resident was dependent upon staff for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/talking off shoes, and personal hygiene, and rolling left and right. Dependent meant the helper did all the effort. Section H., Bladder and Bowel (Bladder;) Indicated the resident was always incontinent. Bladder and Bowel (Bowl;) indicated the resident was always incontinent. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #60's CP indicated a problem area, dated 5/25/2024, that resident was at risk of complications R/T seizure disorder. The goal, created 5/25/2024, indicated the resident would not injure self, secondary due to seizure disorder. An Approach, dated 5/25/2024, directed nursing staff to keep call light in reach. Resident #60's CP indicated a second problem area, dated 5/20/2024, that resident experienced bladder incontinence R/T impaired mobility and history of Cerebral Vascular Accident. The goal, created 5/20/2024, indicated the resident would maintain current level of bladder incontinence. An Approach, dated 11/1/2023, directed nursing staff to keep call light in reach. Resident #60's CP indicated a third problem area, dated 10/20/2023, that resident experienced moisture associated skin damage to her sacrum. The goal, edited 5/20/2024, indicated the resident would maintain integrity. An Approach, dated 11/1/2023, directed nursing staff to turn and reposition every 2 hours. Record review of March 2024, April 2024, and May 2024 facility incident and accident reports did not reveal Resident #60 having had any accidents or falls. Interview and observation on 5/28/2024 at 2:11 PM, revealed Resident #60 in bed on her back. Her right arm was bent across her chest and her left arm was at her left side. Her call light button was clipped on her bed on her right side. Interview with the RP revealed Resident #60 was non-verbal and was unable to utilize her arms, or her hands. Since Resident #60 was unable to use her arms, or her hands, the RP said they did not understand how Resident #60 was supposed to utilize her call button, which was designed to be held in a hand and activated with a thumb/finger, to call for help. The RP was concerned Resident #60 was not able to call for help between regular rounds. The RP also questioned if Resident #60's call light button worked, and RP activated the call button to test it. Upon observation, the call light, which was a light in the hallway and above Resident #60's doorway, did not illuminate when activated. RP was concerned the light did not work after having tested it but did say it had worked when she had activated it prior to today, 5/28/2024. Interview and observation on 5/28/2024 at 2:20 PM, LVN B revealed the call light, which was in the hallway and above Resident #60's doorway, did not illuminate when activated. LVN B walked to the nurse's station to check an electronic call light system monitor (which was an additional notification system,) and the monitor at the nurse's station did not indicate a call had been initiated for the Resident #60's room either. LVN B then entered Resident #60's room and LVN B was observed manually repositioning the call button cord at the wall outlet. LVN B could not get the light to call button to work. LVN B exited the room and returned with different call device equipment. The call light equipment, which LVN B returned with, was a call light paddle, opposed to a button (a call light paddle differed from a call light button as it was designed to be activated by tapping it with a body part.) LVN B connected the call light paddle and tested it, it worked. LVN B called maintenance to perform a maintenance check. Interview on 5/28/2024 at 2:25 PM, the RP revealed she did not understand how Resident #60 would be able to activate the call light paddle either. Until she was asked in interview, she had not thought about Resident #60's inability to call for help. Interview and observation on 5/28/2024 at 2:30 PM, MNT revealed he was called to check on Resident #60's call system. He was observed plugging, and unplugging, Resident #60's call paddle cord at the wall outlet. MNT confirmed the call light paddle was operational. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/29/24 at 2:30 PM, revealed Resident #60 sleeping. There was a call light paddle on her chest, within arm's reach. She was not in distress. Interview on 05/30/24 at 08:46 AM, RN A revealed activation of the call light system inside a resident's room triggered the illumination of a light in the hallway above the resident's door. As well, activation of the call light system, from a resident's room, activated a light and an audible tone on the call light monitor at the nurse's station. A safeguard in place, to ensure a resident's call light system was working correctly, was called [guardian angel rounds.] [Guardian angel rounds] consisted of staff having checked each room daily, which included a check of the call light system. If there was an issue with the call light, staff was supposed to enter the information in the maintenance book, as well as call maintenance. An alternate form of calling staff, for those residents who had a temporarily inoperable call light systems, was the use of a metal bell. Risks posed to a resident, without a working call light system, included the increased risk of falls, skin breakdown, frustration, or having had feelings of neglect. Interview on 05/30/24 at 09:06 AM, LVN C revealed Resident #60 had functional limitations with her upper extremities and was unable to press the call light button with her fingers or utilize a different body part to activate a call light paddle. Having known Resident #60's inability to utilize the call light system, nursing staff utilized two-hour checks to offer services, such as rounds for incontinent care, or to reposition. Observation on 05/30/24 9:30 AM, revealed Resident #60 in bed. Staff was in her room having had provided care. Interview and observation on 05/30/24 at 09:48 AM, CNA B revealed she had been instructed to check on the residents on her hallway, including Resident #60, every two hours. She had a small, laminated card attached to her name badge lanyard that indicated her room-rounds schedule. CNA B knew Resident #60 was without the use of her upper extremities and could not activate her call light system, but she had not been instructed to check on Resident #60 with any increased frequency. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 05/30/24 10:12 AM, ADON A revealed staff was trained to have at least one CNA on each hallway to monitor for call lights; and the goal for having answered a call light was immediate. If a call light system were inoperable, staff was supposed to contact maintenance and add the inoperable equipment to the maintenance log. During the time a call light system was inoperable, a small metal bell was provided for a resident to use during its repair. Residents who were provided a metal bell to call for staff, were also provided with more frequent checks to make sure they were doing ok. A safeguard in place to identity faulty call light systems was [guardian angel rounds,] which were room daily room checks to check for their functionality. If a call light system was inoperable, risked posed to residents were falls and skin breakdown. If there was a physical limitations in a resident's ability to utilize the call light button, they would have been provided an alternate, such a call light paddle. If there was a physical limitations in a resident's ability to utilize the call light paddle, they would have had that limitation noted in the care plan; and that they required alternative methods of having received nursing care. The IDT, which was a team of individuals, devised each resident's comprehensive care plan to address their needs to live up to their highest potential. Record review of Resident #60's comprehensive care plan did not address her inability to utilize the call light system. The comprehensive care plan did not indicate Resident #60 had a disability that made use of the facility's communication system inaccessible. The comprehensive care plan did not indicate an alternative form of communication, or enhanced alternatives, to meet the resident's needs according to Resident #60's plan of care. Interview and observation on 5/30/2024 at 11:05 AM, MNT revealed broken equipment was supposed to be entered into the maintenance book at each nurse's station. At the front of the book, written in red, there was an annotation to [call the MNT for call light issues.] Interview on 05/30/24 at 1:37 PM, the ADM revealed a safeguard in place to check for functioning call light systems in the residents' rooms were [guardian angel rounds.] [Guardian angel rounds] were physical checks performed each morning to check specifically for functioning call light systems. Resident #60's inoperable call light system was unfortunate, however, it was hard to pinpoint the failure, as electronic devices could work one minute and not work the next. She stated her team was trained to identify those deficiencies and correct them as they became apparent. As far as Resident #60's comprehensive care plan, she acknowledged the importance of having addressed her functional limitations and made allowances in her care plan for services. She thought she, and her team, had identified each resident with specific needs, but Resident #60's limitations and specific needs must have been overlooked. The ADM stated Resident #60 received multiple checks throughout the day and her care was not neglected. Record review of the facility's Routine Maintenance Policy, dated March 2006, indicated the facility preformed routine maintenance on floors, walls, fixtures, and equipment. A record review of facility policy titled Care Plan Process, Person Centered Care Plan dated May 5, 2023, reflected: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes trying to understand what each resident is communicating, verbally and nonverbally, identifying What is important to each resident regarding daily routines and preferred activities, and understanding the resident's life before coming to reside in the nursing home. Having following RAI guidelines, develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a residence medical, nursing, mental and psychosocial needs. 11. The person-centered care plan includes: a. Date , b. Problem c. Resident goals for admission and desired outcomes d. Time frames for achievement e. Interventions, discipline specific services, and frequency f. Refusal of services and/or treatment5 a. Evaluation of resident's decision-making capacity b. Educational attempts c. Attempts to find alternative means to address the identified risk/need. g. Discharge plans A record review of facility policy titled Restraints dated May 5, 2023, reflected: 5. Update care plan with the problem, goal, and approaches, which must include: a. Observation b. Release c. Repositioning, at least every 2 hours Ongoing restraint use: The Plan of Care should be updated at least quarterly and with any significant change, including the medical symptoms which continue to warrant the need for a restraint. Record review of the facility's Responding to Call Light Policy, dated May 2023, did not address alternative measures for residents who had limitations to have utilized the facility's communication system in place. 47926

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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** 47772 Based on observation, interview, and record review, the facility failed to adequately equip residents who have disabilities, and were unable to utilize the facility's communication system, with alternative services to meet the resident's needs as identified in the resident's plan or care for 1 of 8 residents (Resident #60) who was reviewed for functioning communication systems. 1. The facility failed to provide Resident #60 with a functioning communication system to call for nursing assistance. 2. The facility failed to provide Resident #60 with a call light system that accounted for Resident #60's functional limitations. This failure placed residents at risk of their needs having gone unmet. Findings included: Record review of Resident #60's Quarterly MDS, dated [DATE], Section A., Identification: Indicated the resident was a [AGE] year-old female, who was admitted to the facility on [DATE]. Section C., Cognitive Patterns: Indicated the resident's cognitive function was severely impaired. Section I., Active Diagnoses: Indicated the resident was diagnosed with Aphasia (which was a comprehension and communication disorder having resulted from damage or injury to the brain,) Hemiplegia (which caused one-sided paralysis,) Cerebral Vascular Accident (which was a condition that caused an interruption of blood flow to the brain,) and Seizure Disorder (which was a sudden alteration of behavior due to a temporary change in the electrical functioning of the brain.) Section GG., Functional Abilities and Goals: Indicated the resident had impairment with both upper extremities (shoulder, elbow, wrist, and hand.) Resident utilized a wheelchair for mobility. Resident was dependent upon staff for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/talking off shoes, and personal hygiene, and rolling left and right. Dependent meant the helper did all the effort. Section H., Bladder and Bowel (Bladder;) Indicated the resident was always incontinent. Bladder and Bowel (Bowl;) indicated the resident was always incontinent. Record review of Resident #60's CP indicated a problem area, dated 5/25/2024, that resident was at risk of complications R/T seizure disorder. The goal, created 5/25/2024, indicated the resident would not injure self, secondary due to seizure disorder. An Approach, dated 5/25/2024, directed nursing staff to keep call light in reach. Resident #60's CP indicated a second problem area, dated 5/20/2024, that resident experienced bladder incontinence R/T impaired mobility and history of Cerebral Vascular Accident. The goal, created 5/20/2024, indicated the resident would maintain current level of bladder incontinence. An Approach, dated 11/1/2023, directed nursing staff to keep call light in reach. Resident #60's CP indicated a third problem area, dated 10/20/2023, that resident experienced moisture associated skin damage to her sacrum. The goal, edited 5/20/2024, indicated the resident would maintain integrity. An Approach, dated 11/1/2023, directed nursing staff to turn and reposition every 2 hours. Record review of March 2024, April 2024, and May 2024 facility incident and accident reports did not reveal Resident #60 having had any accidents or falls. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 5/28/2024 at 2:11 PM, revealed Resident #60 in bed on her back. Her right arm was bent across her chest and her left arm was at her left side. Her call light button was clipped on her bed on her right side. Interview with RP #60 revealed Resident #60 was non-verbal and was unable to utilize her arms, or her hands. Since Resident #60 was unable to use her arms, or her hands, RP #60 did not understand how Resident #60 was supposed to utilizer her call button, which was designed to be held in a hand and activated with a thumb/finger, to call for help. RP #60 was concerned Resident #60 was not able to call for help between regular rounds. During the interview, RP #60 also questioned if Resident #60's call light button worked, and RP #60 activated the call button to test it. Upon observation, the call light, which was a light in the hallway and above Resident #60's doorway, did not illuminate when activated. RP #60 was concerned the light did not work after having tested it but did say it had worked when she had activated it prior to today, 5/28/2024. Interview and observation on 5/28/2024 at 2:20 PM, LVN B revealed the call light, which was in the hallway and above Resident #60's doorway, did not illuminate when activated. LVN B walked to the nurse's station to check an electronic call light system monitor (which was an additional notification system,) and the monitor at the nurse's station did not indicate a call had been initiated for the Resident #60's room either. LVN B then entered Resident #60's room and LVN B was observed manually repositioning the call button cord at the wall outlet. LVN B could not get the light to call button to work. LVN B exited the room and returned with different call device equipment. The call light equipment, which LVN B returned with, was a call light paddle, opposed to a button (a call light paddle differed from a call light button as it was designed to be activated by tapping it with a body part.) LVN B connected the call light paddle and tested it, it worked. LVN B called maintenance to perform a maintenance check. Interview on 5/28/2024 at 2:25 PM, with RP #60 revealed she did not understand how Resident #60 would be able to activate the call light paddle either. Until she was asked in interview, she had not thought about Resident #60's inability to call for help. Interview and observation on 5/28/2024 at 2:30 PM, MNT revealed he was called to check on Resident #60's call system. He was observed plugging, and unplugging, Resident #60's call paddle cord at the wall outlet. MNT confirmed the call light paddle was operational. Observation on 05/29/24 at 2:30 PM, revealed Resident #60 sleeping. There was a call light paddle on her chest, within arm's reach. She was not in distress. Interview on 05/30/24 at 08:46 AM, RN A revealed activation of the call light system inside a resident's room triggered the illumination of a light in the hallway above the resident's door. As well, activation of the call light system, from a resident's room, activated a light and an audible tone on the call light monitor at the nurse's station. A safeguard in place, to ensure a resident's call light system was working correctly, was called [guardian angel rounds.] [Guardian angel rounds] consisted of staff having checked each room daily, which included a check of the call light system. If there was an issue with the call light, staff was supposed to enter the information in the maintenance book, as well as call maintenance. An alternate form of calling staff, for those residents who had a temporarily inoperable call light systems, was the use of a metal bell. Risks posed to a resident, without a working call light system, included the increased risk of falls, skin breakdown, frustration, or having had feelings of neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676308	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Rehabilitation and Care Center	4100 College Park Dr Round Rock, TX 78665

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/30/24 at 09:06 AM with LVN C revealed Resident #60 had functional limitations with her upper extremities and was unable to press the call light button with her fingers or utilize a different body part to activate a call light paddle. Having known Resident #60's inability to utilize the call light system, nursing staff utilized two-hour checks to offer services, such as rounds for incontinent care, or to reposition. Observation on 05/30/24 at 9:30 AM, revealed Resident #60 in bed. Staff was in her room having had provided care. Interview and observation on 05/30/24 at 09:48 AM, CNA B revealed she had been instructed to check on the residents on her hallway, including Resident #60, every two hours. She had a small, laminated card attached to her name badge lanyard that indicated her room-rounds schedule. CNA B knew Resident #60 was without the use of her upper extremities and could not activate her call light system, but she had not been instructed to check on Resident #60 with any increased frequency. Interview and observation on 05/30/24 at 10:12 AM, ADON A revealed staff was trained to have at least one CNA on each hallway to monitor for call lights; and the goal for having answered a call light was immediate. If a call light system were inoperable, staff was supposed to contact maintenance and add the inoperable equipment to the maintenance log. During the time a call light system was inoperable, a small metal bell was provided for a resident to use during its repair. Residents who were provided a metal bell to call for staff, were also provided with more frequent checks to make sure they were doing ok. A safeguard in place to identity faulty call light systems was [guardian angel rounds,] which were room daily room checks to check for their functionality. If a call light system was inoperable, risked posed to residents were falls and skin breakdown. If there was a physical limitation in a resident's ability to utilize the call light button, they would have been provided an alternate, such a call light paddle. If there was a physical limitation in a resident's ability to utilize the call light paddle, they would have had that limitation noted in the care plan; and that they required alternative methods of having received nursing care. The IDT, which was a team of individuals, devised each resident's comprehensive care plan to address their needs to live up to their highest potential. Record review of Resident #60's comprehensive care plan did not address her inability to utilize the call light system. The comprehensive care plan did not indicate Resident #60 had a disability that made use of the facility's communication system inaccessible. The comprehensive care plan did not indicate an alternative form of communication, or enhanced alternatives, to meet the resident's needs according to Resident #60's plan of care. Interview and observation on 5/30/2024 at 11:05 PM with MNT revealed broken equipment was supposed to be entered into the maintenance book at each nurse's station. At the front of the book, written in red, there was an annotation to [call the MNT for call light issues.] (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/30/24 1:37 PM with the ADM revealed a safeguard in place to check for functioning call light systems in the residents' rooms were [guardian angel rounds.] [Guardian angel rounds] were physical checks performed each morning to check specifically for functioning call light systems. Resident #60's inoperable call light system was unfortunate, however, it was hard to pinpoint the failure, as electronic devices could work one minute and not work the next. She stated her team was trained to identify those deficiencies and correct them as they became apparent. As far as Resident #60's comprehensive care plan, she acknowledged the importance of having addressed her functional limitations and made allowances in her care plan for services. She thought she, and her team, had identified each resident with specific needs, but Resident #60's limitations and specific needs must have been overlooked. The ADM stated Resident #60 received multiple checks throughout the day and her care was not neglected. Record review of the facility's Routine Maintenance Policy, dated March 2006, indicated the facility preformed routine maintenance on floors, walls, fixtures, and equipment. Record review of the facility's Care-Plan Process, Person-Centered Care Policy, dated May 2023, indicated the facility was supposed to develop and implement a comprehensive care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards and quality of care. Person-centered care included having tried to understand what each resident was communicating, verbally and nonverbally, having identified what was important to each resident with regards to daily routines and preferred activities, and having understood the resident's life before having come to reside in the nursing home. Having following RAI guidelines, develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a residence medical, nursing, mental and psychosocial needs. Record review of the facility's Responding to Call Light Policy, dated May 2023, did not address alternative measures for residents who had limitations to have utilized the facility's communication system in place.