| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676317 | A. Building<br>B. Wing | 12/04/2025 |

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| The Harrison at Heritage | 4600 Heritage Trace Parkway<br>Fort Worth, TX 76244 |

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) |
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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>(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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident was not given a psychotropic drug unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 5 residents (Resident #132) reviewed for unnecessary medications, in that: The facility failed to ensure Resident #132 was not prescribed a psychotropic drug for anxiety longer than 14 days PRN. Resident #132 was ordered PRN Alprazolam (a benzodiazepine medication used primarily to treat anxiety disorders and severe agitation) on 11/26/25 without a stop date. This deficient practice could place residents at risk of receiving unnecessary psychotropic medications. Findings included: Record review of Resident #132's MDS Assessment (the type of assessment was not listed), dated 12/01/25, reflected he was an [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #132 had a BIMS score of 14, indicating no cognitive impairment. Resident #132's active diagnoses included non-alzheimer's dementia (encompasses a variety of conditions that cause cognitive decline and memory loss beyond what is considered a normal part of aging) and anxiety disorder (a group of mental health conditions that cause fear, dread, and other symptoms that are out of proportion to the situation). Record review of Resident #132's Order Summary Report, dated 12/03/25 reflected the following: Alprazolam Oral Tablet 0.25 MG, Give 1 tablet by mouth every 12 hours as needed for anxiety related to Anxiety Disorder, Unspecified with a start date of 11/26/25. Record review of Resident #132's Care Plan, initiated 12/03/25, did not reflect his use of the anti-anxiety medication. Record review of Resident #132's November 2025 MAR reflected he did not receive any tablets of his ordered PRN Alprazolam medication. Record review of Resident #132's December 2025 MAR reflected he did not receive any tablets of his ordered PRN Alprazolam medication.Observation and interview on 12/02/25 at 10:33 AM, with Resident #132 revealed he did not have any concerns regarding his medications and did not feel anxious or need any medication to help him with his anxiety.Interview on 12/04/25 at 10:21 AM, RN H revealed she cared for Resident #132. RN H said he had an order for PRN Alprazolam but had not received any that she was aware of. RN H said Alprazolam was considered a psychotropic medication and was used to address a resident's anxiety. RN H said it should have a 14-day stop date associated with the order. RN H said when she looked in the system she did not see that the medication had a 14-day stop date. RN H said it would have been the responsibility of the admitting nurse to make sure that they checked with the doctor to add that to the order. RN H said Resident #132 came to the facility with the order in place from the hospital.Interview on 12/04/25 at 3:36 PM, the DON revealed all PRN psychotropic medications must have a 14-day stop date included with the order. The DON said this ensures the facility has the ability to reassess and reevaluate to make sure the medication was appropriate for residents. The DON said when the nurse received an order for a PRN psychotropics the nurse should ask the doctor or NP for the 14-day stop date and include it in the order. The DON said normally she and the ADON would check the orders to make sure the 14-day stop date was included in the order after it was put in the system. The DON said if this stop date was not included in the resident's order then the resident could have medication that was unnecessary for them.Record review of the facility's policy, dated 10/01/25, and titled Use of Psychotropic Medications reflected: 15. Psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted: a. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the MDS assessment accurately reflected the resident status for 1 of 44 residents (Resident #88) reviewed for assessment accuracy.The facility failed to ensure Residents #88's MDS assessments were accurately coded for dialysis treatment. This failure could place residents at risk of not receiving the appropriate care and services to maintain the highest level of well-being.Finding included: Record review of Resident #88's admission MDS assessment, dated 10/27/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #88 had diagnoses of end-stage renal disease (the final stage of chronic kidney disease where the kidneys can no longer filter waste and fluids from the blood effectively), and hypertension (high blood pressure). She had a BIMS score of 15, which indicated her cognition was intact. The MDS did not reflected Resident #88 was receiving dialysis.Record review of Resident #88's care plan, dated 10/23/25, reflected Focus: The resident needs dialysis. Goal: The resident will have immediate intervention should any s/sx of complications from dialysis occur through the review date. Interventions: Check and change dressing daily at access site. Document. Do not draw blood or take B/P in arm with graft. Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis. Monitor labs and report to doctor as needed. Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Monitor/document/report PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock. Observation and interview on 12/02/25 at 1:30 PM revealed Resident #88 in her bed laying down. Resident #88 stated she went for dialysis on Mondays, Wednesdays, and Fridays. She stated the facility provided her with a form to take to dialysis. Resident #88 further revealed her site was dry, clean, and without complications.Interview on 12/04/25 at 11:09 AM, the MDS Coordinator revealed he was the MDS coordinator assigned to the skilled residents, which Resident #88 was one of them. He stated dialysis treatment should be coded in the resident's MDS. MDS Coordinator reviewed Resident #88 admission, and 5-day admission MDS and stated dialysis was not coded. He stated he missed it, and it would require him to complete a modification. He stated it was his responsibility to complete Resident #88's MDS assessment. He stated the Regional MDS completed spot checks, but not all the time. He stated it had not been brought up to his attention. He stated there was no potential risk to the resident, but more of a tracking method for CMS. Interview on 12/04/25 at 2:58 PM, the DON revealed the MDS Coordinators were responsible for completing the residents MDS assessment. She stated the expectations for MDS assessment were for the assessment to be completed accurately and on time. She stated the MDS Coordinator informed her that he missed a code for Resident #88's dialysis treatment in the MDS assessment. The DON stated the potential risk for the assessment not being completed accurately would be, not everything that needed to be capture was captured. Record review of the facility's Resident Assessment - RAI policy, dated 10/01/25, reflected the following: This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by CMS.Policy Explanation and Compliance Guidelines:1. The current version of the RAI (MDS 3.0) will be utilized when conducting a comprehensive assessment of each resident in accordance with the instructions found in the RAI Manual. 2. The assessment will include at least the following: o. Special Treatments and procedures. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 44 residents (Resident #17) reviewed for care plans.The facility failed to ensure Resident #17's care plan addressed the use of a back brace and bilateral foot protectors. This failure could place residents at risk of not receiving the care required to meet their individual needsFindings included:Record review of Resident #17's admission MDS assessment, dated 11/17/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #17 had diagnoses of unspecified fracture of third thoracic vertebra (dislocations of the thoracic and lumbar spine are caused by very high-energy trauma), subsequent encounter for fracture with routine healing, muscle weakness (loss of strength to move, felt as difficulty with tasks, balance issues, or trembling), and other fractures. He had a BIMS score of 15, which indicated his cognition was intact. The MDS reflected Resident #17 had functional limitation in range of motion, impairment on both sides, upper and lower extremity. Record review of Resident #17's care plan, dated 12/02/25, reflected Focus: The resident is risk for falls r/t Gait/balance problems, Paralysis. Goal: The resident will not experience falls or injuries from falls through the review date. The resident will not sustain serious injury through the review date. Interventions: Anticipate and meet the residents' needs. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Care plan did not address the use of back brace or bilateral foot brace. Observation and interview on 12/02/25 at 1:33 PM, revealed Resident #17 was observed in his wheelchair. The resident was wearing his back brace. Resident #17 stated he had a motor accident and had several surgeries. Resident #17 stated he had to wear his back brace when he was out of the bed and could take it off when in bed. Resident #17 stated he put the brace on with staff assistance. He stated his foot braces were to be worn while in bed. Observed the foot braces in the resident's room. He stated he put them on by himself or staff helped him. Resident #17 stated he must wear the back brace for a total of 3 months.Interview on 12/04/25 at 9:52 AM, RN D revealed she was the nurse assigned to Resident #17. She stated Resident #17 admitted to the facility with the back brace and foot protectors. She stated Resident #17's back brace should be worn when out of bed and be removed when in bed. She stated the foot protectors should be worn only when in bed. RN D stated she was not sure if the back brace or foot protectors should be care planned but believed that it should. She stated she was not sure who was responsible for care plans.Interview on 12/04/25 at 11:09 AM, the MDS Coordinator revealed Resident #17's back brace and foot protectors should be care planned. He stated nurses and each department had access to resident's care plans. He stated it was the responsibility of the IDT and nursing staff to ensure residents' care plans were reviewed and updated quarterly. He stated he was not aware Resident #17 was not care planned for the use of the back brace or foot protectors. MDS Coordinator stated the back brace and foot protectors should be care planned because it was an intervention that the facility was providing for the resident. MDS Coordinator stated there was no potential risk if it was not care planned because the service was provided to the residents. Interview on 12/04/25 at 1:11 PM, the Unit Manager revealed Resident #17 admitted to the facility with the back brace and foot protectors. She stated the MDS Coordinators were responsible for care plans. Unit Manager stated she was not sure if the back brace or foot protectors should be care planned. Interview on 12/04/25 at 2:55PM, the DON revealed Resident #17 admitted to the facility with the back brace and foot protectors. She stated the MDS Coordinators were responsible for care plans. She stated she was not aware Resident #17's back brace and foot protectors were not care planned. She stated it should be care plan so that the care team are aware of what was implemented and to continue care. The DON stated she and nurse management followed up to ensure care plans were updated. She stated the potential risk would be lack of care, and ensuring the residents had what they needed. Record review of the facility's Comprehensive Care Plans policy, dated 10/01/25, reflected the following: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standard of quality. 1.The care planning process will include an assessment of the resident's strengths and needs and |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 44 residents (Resident #17) reviewed for quality of care. The facility failed to obtain physician orders for the use of a back brace and bilateral foot protectors for Resident #17. This failure placed residents at risk of not receiving appropriate care and worsening of their conditions. Findings included: Record review of Resident #17's admission MDS assessment, dated 11/17/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #17 had a diagnosis of unspecified fracture of third thoracic vertebra (dislocations of the thoracic and lumbar spine are caused by very high-energy trauma), subsequent encounter for fracture with routine healing, muscle weakness (loss of strength to move, felt as difficulty with tasks, balance issues, or trembling), and other fractures. He had a BIMS score of 15, which indicated his cognition was intact. The MDS reflected Resident #17 had functional limitation in range of motion, impairment on both sides upper and lower extremity. Record review of Resident #17's care plan, dated 12/02/25, reflected Focus: The resident is risk for falls r/t Gait/balance problems, Paralysis. Goal: The resident will not experience falls or injuries from falls through the review date. The resident will not sustain serious injury through the review date. Interventions: Anticipate and meet the residents' needs. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Care plan did not address the use of back brace or bilateral foot brace. Observation and interview on 12/02/25 at 1:33 PM, revealed Resident #17 was observed in his wheelchair. The resident was wearing his back brace. Resident #17 stated he had a motor accident and had several surgeries. Resident #17 stated he had to wear his back brace when he was out of bed and could take it off when in bed. Resident #17 stated he put the brace on with staff assistance. He stated his foot braces were to be worn while in bed. Observed the foot braces in the resident's room. He stated he put them on by himself or staff helped him. Resident #17 stated he must wear the back brace for a total of 3 months. Record review of Resident #17's November and December 2025 physician orders reflected there were no orders for the use of a back brace or bilateral foot braces. Interview on 12/04/25 at 9:48 AM, CNA F revealed she was the CNA assigned to Resident #17. She stated Resident #17 had a brace that should be worn while up out of bed, and foot protection braces must be worn while in bed to keep his feet straight and out of angle. She stated Resident #17 admitted with both back brace and foot protection braces. She stated staff help him put them on and Resident #17 adjust for his comfort. CNA F stated she was not sure of any physician orders. Interview on 12/04/25 at 9:52 AM, RN D revealed she was the nurse assigned to Resident #17. She stated Resident #17 admitted to the facility with the back brace and foot protectors. She stated Resident #17's back brace should be worn when out of bed and be removed when in bed. She stated the foot protectors should be worn only when in bed. RN D stated Resident #17 should have physician orders for both back brace and foot protectors. RN D reviewed Resident #17's physician orders and stated she did not see any physician orders. She stated she knows Resident #17 had orders, but she could not locate them. RN D stated nurses should ensure orders were in the system, however, the admitting nurse was responsible for putting in orders in the system. She stated Resident #17 was alert and oriented and knew when to put the brace on and when to remove them. She stated the potential risk would be not putting the back brace, foot protectors appropriately or staff forget to put them on. Interview on 12/04/25 at 1:11 PM, the Unit Manager revealed Resident #17 should have physician orders for the back brace and foot protectors. She stated Resident #17 did not have any orders until she put them in that day (12/04/25). Unit Manager stated the admitting nurse was responsible for putting orders in the system. She stated Resident #17 was alert and oriented and could voice when he wanted them on or off. Unit Manager stated the potential risk of not having physician orders would be staff not knowing Resident #17 must have braces on and could cause more damage due to his injuries. Interview on 12/04/25 at 2:55PM, the DON revealed Resident #17 admitted to the facility with the back brace and foot protectors. She stated physician orders should have been obtained so that they could monitor when Resident #17 had the brace and foot protectors on. The DON stated it was the responsibility of the admitting charge nurse and the nurse management to ensure all physician orders were obtained and put in the system. She stated she was not aware Resident #17 did not have orders for his back brace or foot protectors. The DON stated the potential risk of not having physician orders would be someone coming |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings for 1 of 3 residents (Resident #102) reviewed for tube feedings.The facility failed to ensure Resident #102's tube feeding was administered per physician orders at a rate of 55 ml per hour continuously on 12/02/25 and 12/03/25. This failure could affect residents receiving enteral nutrition/hydration and place them at risk of overfeeding. Findings included:Record review of Resident #102's Quarterly MDS assessment, dated 09/05/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE], the BIMS section was blank due to Resident #102 having short- and long-term memory problems and due to his cognitive skills for daily decision being severely impaired. Resident #102 was dependent on staff with eating and utilized a feeding tube. Resident #102's diagnoses included Aphasia (communication disorder), Stroke (blood supply to the brain is interrupted, due to a blocked blood vessel or bleeding in the brain), Hemiplegia (partial or total paralysis) or hemiparesis (weaknesses on one side of the body). Record review of Resident #102's care plan revealed Resident #102 required tube feedings related to Dysphagia (difficulty swallowing). Goal: Resident #102 would maintain adequate nutritional and hydration status as evidenced by weight stable, no signs or symptoms of malnutrition, or dehydration. Resident #102's insertion site would be free of infection. Interventions included the Registered Dietician to evaluate quarterly and as needed. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. Speech therapy and treatment as ordered. Resident #102 was dependent with tube feeding and water flushes. See physician orders for current feeding orders. Record review of Resident #102's December 2025 Medication Administration Record reflected: Enteral Feed Order every shift Nutren 1.5 at 55 ml/hour via feeding tube. Up at (blank) to run continuously until total volume of ml administered. May remove for care and services. Start Date 11/29/25.G-Tube-Dual Pump Flush 45 cubic centimeters per hour, water every shift.G-Tube -Dual Pump Water Bag Change every night shift Nutren 2.0 0.08 gram-2kcal/ml at 55ml/hour x 22hours. Start Date 2/27/25.Observation and interview on 12/02/25 at 12:07 PM with Resident #102 revealed he was in his room sitting in a recliner chair visiting with family. The Family Member stated Resident #102 was nonverbal in communication and appeared sleepy and very drowsy. When the Family Member was asked about Resident #102's feeding, it was stated that Resident #102 had gone through some formula changes and had a flow rate of 55 ml/hour, but had recently observed an increase to 60 ml/hour. The Feeding Tube machine was observed to read a flow rate of 60 ml/hour continuously. Observation of the formula bag revealed Resident #102, Nutren 1.5, 60 ml/hour, 12/02/25, 11:00 AM. Observation and interview on 12/03/25 at 12:27 PM with LVN C revealed the Feeding Tube machine off. The formula bag revealed Resident #102, Nutren 1.5, 60 cc, 12/03/25, 6:52 AM. LVN C stated he administered Resident #102's formula that morning at a rate of 60 ml/hour with continuous feeding. LVN C reviewed Resident #102's orders for his tube feeding and revealed the flow rate should have been 55 ml/hour. According to LVN C, having an increase in flow rate placed Resident #102 at risk of fluid overload. LVN C stated Resident #102's order was updated and should have been at 60ml per [timeframe] , however, he could not recall when the order was increased. LVN stated nurses were responsible for ensuring orders were entered correctly and were responsible for following physician orders. LVN C stated the Unit Managers were responsible for reviewing all orders to ensure they were entered correctly. Interview on 12/03/25 at 1:08 PM with LVN C revealed he contacted the physician to confirm the order, and the physician stated Resident #102 was to remain at a flowrate of 60ml per [timeframe] continuous with intermittent 2 hour down time. LVN C stated not following physician orders, updating orders, or entering the updated orders, placed Resident #102 at risk of losing nutrients and weight. LVN C advised that nurses were responsible for updating the new orders provided by physicians in a timely manner.Interview on 12/04/25 at 1:10 PM with Unit Manger revealed nurses were responsible for entering and updating physician orders as they were given. The Unit Manager stated she was responsible for reviewing all orders to ensure they were properly entered. However, for the past couple of months, it had only been her that was responsible for Unit Manager tasks, and she fell behind. The Unit Manager stated although Resident #102's order had not been updated, he was receiving 60 ml/hour. The Unit Manager stated nursing staff should clarify the new order with the physician, notify family or the responsible party that the order changed, and document the consent or refusal for the new order. The Unit Manager further stated |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676317 | A. Building<br>B. Wing | 12/04/2025 |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 of 2 residents (Residents #82 and #88) reviewed for dialysis.1. The facility failed to ensure Resident #82 and Resident #88 had a physician order to complete dialysis treatment. This failure could place residents at risk of inadequate monitoring after returning to facility. Findings included:Resident #82Record review of Resident #82's admission MDS assessment, dated 11/25/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #82 had diagnoses of end-stage renal disease (the final stage of chronic kidney disease where the kidneys can no longer filter waste and fluids from the blood effectively) and chronic obstructive pulmonary disease (COPD). He had a BIMS score of 09, which indicated his cognition was moderately impaired. The MDS reflected Resident #82 received dialysis.Record review of Resident #82's care plan, dated 12/02/25, reflected Focus: The resident needs dialysis r/t renal failure. Goal: The resident will have immediate intervention should any s/sx of complications from dialysis occur through the review date. Interventions: Do not draw blood or take B/P in arm with graft. Monitor vital signs. Notify MD of significant abnormalities. Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds.Record review of Resident #82's EHR reflected communication forms regarding Resident #82's pre- and post-dialysis vital signs monitoring were filled out by the nurse on duty.Record review of Resident #82's November and December 2025 physician's order reflected there were no orders for completing dialysis or to obtain and document vital signs prior to Resident #82 leaving for dialysis and upon return from dialysis.Observation on 12/02/25 at 10:33 AM, revealed Resident #82 in bed. An attempt was made to interview Resident #82, but the resident did not stay awake for the interview. The resident was in no apparent distress.Resident #88Record review of Resident #88's admission MDS assessment, dated 10/27/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #88 had diagnoses of end-stage renal disease (the final stage of chronic kidney disease where the kidneys can no longer filter waste and fluids from the blood effectively) and hypertension (high blood pressure). She had a BIMS score of 15, which indicated her cognition was intact. The MDS did not reflect Resident #88 was receiving dialysis.Record review of Resident #88's care plan, dated 10/23/25, reflected Focus: The resident needs dialysis. Goal: The resident will have immediate intervention should any s/sx of complications from dialysis occur through the review date. Interventions: Check and change dressing daily at access site. Document. Do not draw blood or take B/P in arm with graft. Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis. Monitor labs and report to doctor as needed. Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Monitor/document/report PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock. Record review of Resident #88's EHR reflected communication forms regarding Resident #88's pre- and post-dialysis vital signs monitoring were filled out by the nurse on duty.Interview and observation on 12/02/25 at 1:30 PM, Resident #88 revealed she went for dialysis on Mondays, Wednesdays, and Fridays. She stated the facility provided her with a form. Resident #88 further revealed her site was dry, clean and without complications.Record review of Resident #88's October, November, and December 2025 physician's order reflected there were no orders for completing dialysis on Monday, Wednesday, or Fridays or to obtain and document vital signs prior to Resident #88 leaving for dialysis and upon return from dialysis.Interview on 12/03/2025 at 2:29 PM, LVN C revealed he was the nurse assigned to Resident #88 today (12/03/25) and it was his first time working with her. He stated Resident #88's nurse was usually RN D. LVN C stated Resident #88 was a dialysis patient and resident leaves for her chair time at around 4:30AM on Mondays, Wednesdays and Fridays. LVN C stated Resident #88 should have an order for dialysis. LVN C reviewed Resident #88's physician orders and stated resident did not have any orders pertaining to dialysis. He said the admitting nurse was responsible for obtaining and putting in physician orders into the system. LVN C said the potential risk of not having physician orders would be resident not going to dialysis. Interview on 12/03/25 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 residents (Resident #8) reviewed for pharmacy services. The facility failed to ensure Resident #8 received her morning medications when LVN G prepared the medications and set them down on the hall railing to assist another resident. LVN G did not return to retrieve the medications off the hall and administer them to Resident #8. These failures could place residents at risk for medication error, drug diversion, and delay in medication administration. Findings included: Record review of Resident# 8's Entry MDS assessment, dated 08/23/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE], a BIMS of 07 indicated[PH1] severe cognitive with impairment. Resident #8's diagnoses included hypertension (high blood pressure) and Thyroid Disorder (condition that affect the thyroid gland that produces hormones that regulate metabolism and other bodily functions). The resident was dependent on facility staff to assist with toileting, bathing, and personal hygiene. Resident #8 required assistance with eating and oral hygiene. Record review of Resident #8's care plan revealed Resident #8 has hypothyroidism related to use/side effects of medication. Goal: Resident #8 will be free from signs and symptoms of hypothyroidism. Interventions included: Give thyroid replacement therapy as ordered, monitor side effects. Monitor /document/report any signs and symptoms of hyperthyroidism due to medication; obtain lab work as ordered. Stress the importance of taking the medication every day. Record review of Resident #8's MAR reflected at 5:00 AM on 12/03/25, LVN C provided Resident #8 with Liothyronine Sodium Oral tablet 5 MCG and Levothyroxine Sodium Oral Tablet 25 MCG. Record review of Resident #8's physician's orders dated 12/04/25 reflected an order for Levothyroxine Sodium oral tablet 25 mcg. Give 1 tablet by mouth in the morning for hypothyroidism. Start date 09/28/25. Also, Liothyronine Sodium oral tablet 5 mcg. Give 1 tablet by mouth in the morning for hyperthyroidism. Start date 08/17/25. Observation on 12/03/25 at 12:47 PM, on 600 Hall in the handrail revealed a clear medication cup with 606B written in black, a pink pill and a white pill. Observation and interview on 12/03/25 at 12:50 PM, with LVN C revealed medication cup labeled 606B, pink pill and white pill. LVN C stated he would review Resident #8's MAR and orders to see what medications had been administered. LVN C observed the nurse medication cart to reveal Resident #8's morning medication was Levothyroxine Tab 25 MCG, give 1 tablet by mouth every morning and Liothyronine Tab 5 MCG, Give 1 tablet by mouth in the morning. LVN C stated the early morning medications were administered by the overnight nursing staff prior to the end of their shift of 10:00 PM - 6:00 AM. LVN C stated he was not informed any residents had missed dose of medications. LVN C stated he had not previously seen the medication in the handrail. LVN C stated he needed to notify the physician of the missed doses. LVN C stated nurses were responsible for administering medications. LVN C stated when he administered medications he stood by the resident to ensure there was no choking, and medication had been administered properly. LVN C stated having found medication on the hall placed residents at risk of missed doses of medication, residents finding the medication and administering medication that does not belong to them. Interview on 12/04/2025 at 1:07 PM, the Unit Manager revealed she was notified about the medication found on the hall. The Unit Manager stated 5am medications were administered by the 10:00 PM - 6:00 AM nursing staff. The Unit Manager stated all nurses administering medications were to verify the dose and utilize the 5 rights of medication administration. The Unit Manager stated nurses should match the resident name, drug, dose, route, and right time of administration and ensure to stand and observe residents taking the medication. The Unit Manager stated not following the medication administration protocol, it placed residents at risk of having allergic reactions to medications that did not belong to them if they were to find and take medications that did not belong to them. Interview on 12/04/2025 at 2:51 PM, the DON revealed she was notified about medications found on the hallway. According to the DON when she spoke with the overnight nurse LVN G stated he was going to administer medication to Resident #8 when he saw another resident attempting to get out of bed and his attention was redirected to assist. According to the DON, not following the proper protocol placed Resident #8 a risk of not getting the medication she needed and others at risk of taking medication that did not belong to them. Interview on 12/04/25 at 3:15 PM, LVN G revealed he popped Resident #8's medication at the cart and was headed to Resident #8 when he observed another resident attempted to get out of bed. LVN G stated he sat the |

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| F 0914<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide bedrooms that don't allow residents to see each other when privacy is needed.<br><br>(continued on next page) |

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| F 0914<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure each bed had ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains for 2 of 21 residents (Resident #16 and #82) reviewed for privacy curtains. The facility failed to ensure Residents #16 and #82 were ensured full visual privacy by not having ceiling suspended curtains that extend around the bed. These failures could place residents at risk of lowered self-esteem. Findings included:1. Record review of Resident #16's annual MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included morbid obesity, chronic respiratory failure (ineffective breathing), heart failure, depression, and anxiety. His BIMs score was 11, which indicated he had moderate cognitive impairment. His Functional Ability assessment indicated he required staff assistance with most of his ADLs. His Bowel and Bladder assessment reflected he was always incontinent of bowel and bladder. Record review of Resident #16's care plan, dated 11/06/25, reflected he did not participate in facility activities, had a self-care deficit, was a high fall risk with actual falls, had bowel incontinence, and was at risk of pressure ulcers.Observation and interview on 12/02/25 at 10:17 AM of Resident #16's of room revealed his privacy curtain only covered part of his bed, leaving more than half of his bed unprotected. It appears at least one more section of the curtain would need to be added. The resident's bed is positioned with the foot towards the door, and the side facing the room. Resident #16 stated staff pull the curtain to cover the end of his bed from the doorway when they come in to perform incontinence care, but the rest of the bed is not covered. He stated it makes him nervous that someone will be able to see him when he is being changed. Resident #16 stated the curtains had been that way since he was admitted . 2. Record review of Resident #82's admission MDS, dated [DATE], reflected he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included emphysema, stroke, kidney failure, and diabetes. His BIMS score was 9, indicating moderate cognitive impairment. His Functional Ability assessment indicated he required staff assistance with all his ADLs. His bowel and bladder assessment indicated he was always incontinent of bowel and bladder. Record review of Resident #82's care plan, dated 11/23/25, indicated he had a self-care deficit, was cognitively impaired, was incontinent related to immobility, and required dialysis for his kidney failure. Observation and interview on 12/02/25 at 10:33 AM Resident #82's privacy curtain did not provide full privacy. The resident had a curtain that separated his bed from his roommate, leaving the foot of his bed exposed. Interview attempted with the resident was not successful, the resident would not stay aware or answer questions. Interview on 12/03/25 at 9:53 AM CNA-A stated they pull the curtain between Resident #82's bed and his roommate, and keep the door closed to provide privacy when providing care. With Resident #16 she stated the curtain covered the end and part of the side of the bed, and they also kept the door closed for privacy when providing care. She stated she had not thought of notifying anyone about the curtains. Interview on 12/03/25 at 10:00 AM Housekeeper-B stated she was unaware of any room needing additional privacy curtains. She stated she would have to let her supervisor know when curtains needed to be addressed. Interview on 12/04/25 at 11:00 AM the Maintenance Director stated he was unaware of any curtains that needed to be added. He stated staff submit a work order when they need something addressed, and he did not think anyone had done so for the curtains.Interview on 12/04/25 at 11:20 AM the DON stated the privacy curtains should provide full coverage to ensure full privacy. She stated the nursing staff were responsible for notifying housekeeping if a curtain needed to be changed out, and maintenance if a curtain needed to be hung. She stated someone should have let her or the ADON know about any room not having full privacy coverage. She stated it was important to provide privacy for each resident for their dignity, as well as to establish their area of the room. The DON stated there was not a policy specific to privacy curtains. She did provide a policy on Safe Homelike Environment.Review of the facility's policy Safe and Homelike Environment, dated 10/01/25 reflected: 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. |