STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676353	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado at Stone Oak	19638 Stone Oak Parkway San Antonio, TX 78258

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 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** 28619 Based on observations, interviews, and record reviews the facility failed to provide an assessment that accurately reflected the resident's status for 1 (Resident #26) of 32 residents reviewed for assessment accuracy. The facility failed to reflect Resident #26 used a Bipap machine (bilevel positive airway pressure device or Type of respiratory support therapy that uses positive air pressure to help individuals breathe, especially individuals who have sleep apnea (a condition that affects breathing at night) or other respiratory conditions) machine on her admission MDS. This failure placed Residents at risk of having inaccurate assesments to include those who need a bipap machine at night, that could lead to Residents careplan not being correct and Resident not recieving care as needed. The findings included: Record review of Resident # 26's EMR and face sheet dated 05/07/2025 reflected she was admitted to the facility on [DATE]. Her diagnoses included: displaced bicondylar fracture of right tibia (the shinbone is broken in two parts affecting both the medial and lateral bumps and the fragments are out of alignment), diabetes (a chronic condition where the body either does not produce enough insulin or cannot use the insulin it produces), morbid obesity (a severe form of obesity defined by a body mass index of 40 or higher with related health complications), and shortness of breath (difficulty breathing or feeling of not getting enough air) Record review of Resident #26's admission MDS assessment dated [DATE] reflected she was admitted from a short-term general hospital. She could understand others and be understood. She scored a 15/15 on her BIMS which signified she was cognitively intact. She had impairment of her upper extremity but could ambulate with a walker. Resident #26 required moderate assistance from staff with her ADL's. She was continent of bowel and bladder. Resident #26's Bipap was not reflected. Record review of Resident #26's comprehensive care plan date initiated 04/23/2025 and revised on 05/02/2025 reflected Focus, resident has an ADL self-care performance deficit r/t GENERALIZED WEAKNESS. Record review of Resident #26's Order Summer Report, Active as of: 05/07/2025 did not reflect a physician's order for bipap. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #26's NURSING-Skilled Assessment-V2 dated 04/28/2025 reflected 4. Require use of CPAP, BIPAP or Trilogy? and Yes was checked. Record review of Resident #26's Skilled Nursing Note dated 04/27/2025 reflected Wears CPAP at bedtime. Observation on 05/06/2025 at 11:00 am revealed Resident #26 was in her room lying in bed with a Bipap machine on her bedside stand with the connected tubing and mask closed in the top drawer. Interview on 05/06/2025 at 11:02 am with Resident #26, she stated she used the Bipap at night and brought it with her from the hospital. She stated she needed the Bipap at night for extra oxygen and she used it every night. She stated she would put the Bipap mask on herself and the settings were preset so all she had to do was turn on the machine. Observation on 05/07/2025 at 10:00 am of Resident #26 in her room revealed lying on her bed and a Bipap machine was on her bedside stand. Observation on 5/08/2025 at 09:00 am of Resident #26 revealed she was in her room, lying on her bed and a Bipap machine was on her bedside stand. Interview on 05/07/2025 at 4:30 pm with the DON in her office, she stated Resident #26's Bipap was considered a treatment and she was not aware it was not reflected on her admission MDS. She stated without the accurate reflection of what Resident #26's needs were, she was at risk for inadequate care. Interview on 05/08/2025 at 12:10 pm with LVN A, who was the charge nurse on Resident #26's hall, she stated Resident #26 had a Bipap and used it every night. Interview on 05/09/2025 at 1:27 pm with the MDS nurse revealed, she was not aware Resident #26 had used Bipap and it was not reflected on her admission MDS assessment. She stated not having her needs reflected could result in missed care. Interview on 05/09/2025 at 2:00 pm with the ADM who was accountable for the MDS's, he stated he was not aware Resident #26's Bipap was not reflected on her admission MDS, and the MDS needed to accurately reflect the residents care and needs, or they could be missed, and the resident would not have her health needs met. Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, October 2023 reflected The RAI process has multiple regulatory requirements . (1) the assessment accurately reflects the resident's status.

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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 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** 28619 Based on observations, interviews and record reviews, the facility failed to ensure that the comprehensive person-centered care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 (Resident #26) of 32 residents reviewed for comprehensive care plans. The facility failed to reflect Resident #26 used a Bipap machine (bilevel positive airway pressure device or Type of respiratory support therapy that uses positive air pressure to help individuals breathe, especially individuals who have sleep apnea (a condition that affects breathing at night) or other respiratory conditions) machine and Resident #26's shortness of breath diagnosis was not reflected on her comprehensive care plan. This failure affects residents who need a bipap machine at night and could result in lack of oxygen to the brain. The findings included: Record review of Resident # 26's EMR and face sheet dated 05/07/2025 reflected she was admitted to the facility on [DATE]. Her diagnoses included: displaced bicondylar fracture of right tibia (the shinbone is broken in two parts affecting both the medial and lateral bumps and the fragments are out of alignment), diabetes (a chronic condition where the body either does not produce enough insulin or cannot use the insulin it produces), morbid obesity (a severe form of obesity defined by a body mass index of 40 or higher with related health complications), and shortness of breath (difficulty breathing or feeling of not getting enough air) Record review of Resident #26's admission MDS assessment dated [DATE] reflected she was admitted from a short-term general hospital. She could understand others and be understood. She scored a 15/15 on her BIMS which signified she was cognitively intact. She had impairment of her upper extremity but could ambulate with a walker. Resident #26 required moderate assistance from staff with her ADL's, and she was continent of bowel and bladder. Resident #26's Bipap was not reflected on the MDS. Record review of Resident #26's comprehensive care plan date initiated 04/23/2025 and revised on 05/02/2025 reflected Focus, resident has an ADL self-care performance deficit r/t GENERALIZED WEAKNESS. Resident #26's Bipap was not reflected on the comprehensive care plan. Record review of Resident #26's Order Summer Report, Active as of: 05/07/2025 did not reflect a physician's order for bipap. Record review of Resident #26's NURSING-Skilled Assessment-V2 dated 04/28/2025 reflected 4. Require use of CPAP, BIPAP or Trilogy? and Yes was checked. Record review of Resident #26's Skilled Nursing Note dated 04/27/2025 reflected Wears CPAP at bedtime. (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 05/06/2025 at 11:00 am revealed Resident #26 was in her room lying in bed with a Bipap machine on her bedside stand with the connected tubing and mask closed in the top drawer. Interview on 05/06/2025 at 11:02 am with Resident #26, she stated she used the Bipap at night and brought it with her from the hospital. She stated she needed the Bipap at night for extra oxygen and she used it every night. She stated she would put the Bipap mask on herself and the settings were preset so all she had to do was turn on the machine. Observation on 05/07/2025 at 10:00 am of Resident #26 in her room revealed lying on her bed and a Bipap machine was on her bedside stand. Observation on 5/08/2025 at 09:00 am of Resident #26 revealed she was in her room, lying on her bed and a Bipap machine was on her bedside stand. Interview on 05/07/2025 at 4:30 pm with the DON in her office, she stated Resident #26's Bipap needed to be reflected on her care plan to show she needed the supplemental oxygen at night, or it could be missed and result in hypoxia (low oxygen levels). Interview on 05/08/2025 at 12:10 pm with LVN A, who was the charge nurse on Resident #26's hall, she stated Resident #26 had a Bipap and used it every night. Interview on 05/08/2025 at 2:45 pm with LVN B, who was the nurse who admitted Resident #26, she stated she did not know Resident #26 had a Bipap machine and thought someone may have brought it into the facility for her the next day. She stated she was aware Resident #26 used Bipap at night. She stated Resident #26's comprehensive care plan needed to reflect her needs or care could be missed. Interview on 05/09/2025 at 1:27 pm with the MDS nurse revealed, she was not aware Resident #26 had used Bipap and it was not reflected on her comprehensive care plan. She stated not having her needs reflected on her care plan could result in missed care. Record review of the facility policy and procedure titled Care Plans-Comprehensive revised dated September 2010 reflected An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on interviews and record reviews, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one Resident (Resident #294) of 4 Residents reviewed for pressure sore management. 1. LVN C failed to document an accurate skin assessment for Resident #294 on 05/08/2025. This failurecould place Resident at risk on not recieving appropriate care leading to worsening of skin condition. The findings included: 1. Record review of Resident #294's EMR, electronic face sheet dated 05/03/2025 reflected she was admitted to the facility on [DATE]. Her diagnoses included: fracture of upper end of right humerus (break or crack in the bone located at the upper part of the arm near the shoulder joint), fracture of lower end of left radius (bone in forearm breaks near the wrist joint), chronic kidney disease (moderate decrease in kidney function), diabetes mellitus (group of diseases that affect how the body uses blood sugar) and edema (swelling caused by excess fluid trapped in the body's tissues). Review of Resident #294's EMR revealed Resident #294 was not at the facility long enough for an admission MDS assessment. Record review of Resident #294's comprehensive care plan initiated on 05/03/2025 reflected Focus, resident has a pressure ulcer, Interventions, administer treatments as ordered and monitor for effectiveness. Record review of Resident #294's Active Orders As of: 05/09/2025 reflected Right Buttock (Stage 3))-cleanse with wound cleaner/Ns, pat dry. Apply triad (unique wound care product that combines the benefits of a protective ointment and a moisture barrier cream. This cream is zinc oxide based). to affected area, and cover with DD, day shift, Monday, Wednesday, and Friday for Sacrum (a triangular bone at the base of the spinal column that connects with or forms a part of the pelvis), The wound order was dated 05/05/2025. Record review of the facility pressure sore log dated 05/07/2025 reflected Resident #294 had a Stage 3 pressure sore to the sacrum and date of onset was 05/03/2025 her day of admission. Record review of Resident #294's TAR dated May 2025 reflected she received the ordered wound treatment for her sacrum on Monday, 05/05/2025 and Wednesday, 05/07/2025. Record review of an assessment for Resident #294 by LVN C, completed dated 05/08/2025 reflected SECTION 4. Integumentary/Infection Status under Skin, wounds present was marked a no. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/9/2025 at 1:10 pm with LVN C, she stated she made a mistake by marking no to wounds on Resident #294's nursing assessment. She stated proper documentation in resident records was important because the record was reviewed by other providers and could affect the resident's care negatively. She stated she knew Resident #294 had a wound. In an interview on 05/09/2025 at 1:20 pm with the DON, she stated documentation and assessments needed to be accurate and was a professional standard due to the importance of correct health information being passed between care providers and could result in a negative outcome such as a wound not being treated due to a documentation problem. Review of the facility policy and procedure titled Physician Orders revised January 2020 reflected Physician orders include b. Treatments, Medications, diets, therapy, or any treatment may not be administered to the patient without a written order from the attending physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observation, interviews and record reviews, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 resident (Resident #293) of 32 residents reviewed for safe environments. The facility failed to ensure Resident #293 did not have flammable materials near her oxygen. This deficient practice places residents on oxygen therapy at risk for burns. The findings included: Record review of Resident #293's EMR, electronic face sheet dated 05/08/2025 reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: hemiplegia and hemiparesis (neurological conditions resulting from stroke or other brain damage, affecting one side of body. Hemiplegia is complete paralysis, while hemiparesis is weakness or impaired movement.) following cerebral infarction, (a type of stroke where blood supply to the brain is disrupted) acute respiratory failure with hypoxia (a condition where the lungs fail to adequately transfer oxygen into the blood, leading to low oxygen levels and potentially tissue hypoxia), diabetes mellitus (a chronic metabolic disorder characterized by persistently high blood sugar levels), neuromuscular dysfunction of bladder (arises from damage or malformation of nerves controlling the bladder) and allergic rhinitis (an allergy that causes inflammation of the nose and nasal passages). Record review of Resident #293's admission MDS assessment dated [DATE] reflected she could understand others and be understood. She scored a 06/15 on her BIMS which signified she was severely cognitively impaired. She used a walker or manual wheelchair for locomotion. Resident #293 required extensive assistance with ADL's. She had shortness of breath and trouble breathing when lying flat. She received oxygen therapy while at the facility. Record review of Resident #293's comprehensive care plan initiated on 04/25/2025 and revised on 05/06/2025 reflected Focus, resident has oxygen therapy as needed, intervention, provide oxygen as ordered. Record review of Resident #293's Order Summer Report, Active as of: 05/08/2025 reflected Oxygen at 2L per nasal cannula as needed, order active as of 05/06/2025. Observation on 05/06/2025 at 11:10 am revealed Resident #293 in her room lying in bed. Oxygen was infusing at 2L/min via nasal cannula. A tube of Carmex lip balm was on her bedside table and the igredients listed for the Carmex lip balm included 45.3% of white petrolatum. In an interview on 05/06/2025 at 11:11 am with Resident #293, she stated she used the Carmex and lathered it onto her lips for moisture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/07/2025 at 4:30 pm with the DON in her office, she stated Resident #293 should not have the Carmex while she was administered oxygen. She stated she did not know why someone had not checked the tube of lip balm. She stated oxygen can react with oily substances and could cause burns. In an interview on 05/08/2025 at 12:10 pm with LVN A revealed she had started work at the facility recently and was not aware Resident #293's lip balm was flammable, or she would have taken it out of the resident's room and found a non-flammable alternate. Record review of facility policy and procedure titled Oxygen Administration, revised October 2010 reflected 20. Instruct the resident, his/her family, visitors, and roommate (if any) of the oxygen safety precautions. Provide the resident with a written copy of the Oxygen Safety handout. Record review of the NFPA oxygen handout titled Medical Oxygen Safety dated 2016, reflected Safety Tips, Body oil, hand lotion and items containing oil and grease can easily ignite. Keep oil and grease away from oxygen in use.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observation, interviews and record reviews the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals and preferences for 1 resident (Resident #26) out of 3 residents observed for respiratory therapy. The facility failed to obtain physician orders for Resident #26's Bipap she used each night at the facility since her admission on 04/23/2025. This failure place residents who reside at the facility at risk for inaccurate care and communication of health conditions to other providers. The findings included: Record review of Resident # 26's EMR and face sheet dated 05/07/2025 reflected she was admitted to the facility on [DATE]. Her diagnoses included: displaced bicondylar fracture of right tibia (the shinbone is broken in two parts affecting both the medial and lateral bumps and the fragments are out of alignment), diabetes (a chronic condition where the body either does not produce enough insulin or cannot use the insulin it produces), morbid obesity (a severe form of obesity defined by a body mass index of 40 or higher with related health complications), and shortness of breath (difficulty breathing or feeling of not getting enough air) Record review of Resident #26's admission MDS assessment dated [DATE] reflected she was admitted from a short-term general hospital. She could understand others and be understood. She scored a 15/15 on her BIMS which signified she was cognitively intact. She had impairment of her upper extremity but could ambulate with a walker. Resident #26 required moderate assistance from staff with her ADLs. She was continent of bowel and bladder. Resident #26's Bipap machine was not reflected. Record review of Resident #26's comprehensive care plan date initiated 04/23/2025 and revised on 05/02/2025 reflected Focus, resident has an ADL self-care performance deficit r/t GENERALIZED WEAKNESS. Record review of Resident #26's Order Summer Report, Active as of: 05/07/2025 did not reflect a physician's order for bipap. Record review of Resident #26's NURSING-Skilled Assessment-Version 2 dated 04/28/2025 reflected 4. Require use of CPAP, BIPAP or Trilogy? and Yes was checked. Record review of Resident #26's Skilled Nursing Note dated 04/27/2025 reflected Wears CPAP at bedtime. Observation on 05/06/2025 at 11:00 am revealed Resident #26 was in her room lying in bed with a Bipap machine on her bedside nightstand with the connected tubing and mask closed in the top drawer. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/06/2025 at 11:02 am with Resident #26, she stated she used the Bipap at night and brought it with her from the hospital. She stated she needed the Bipap at night for extra oxygen and she used it every night. She stated she would put the Bipap mask on herself and the settings were preset so all she did was turn on the machine. Observation on 05/07/2025 at 10:00 am of Resident #26 in her room revealed her lying on her bed and a Bipap machine was on her bedside stand. Observation on 5/08/2025 at 09:00 am of Resident #26 revealed she was in her room, lying on her bed and a Bipap machine was on her bedside stand. In an interview on 05/07/2025 at 4:30 pm with the DON in her office, she stated Resident #26 needed a physician's order for her Bipap and she did not know why it was not obtained when she was admitted . She stated without a physician's order, the treatment could be given at the wrong setting or time and cause discomfort or hypoxia. She stated the Bipap needed to have a physician's order which was considered professional standards for any treatment. In an interview on 05/08/2025 at 12:10 pm with LVN A, who was the charge nurse on Resident #26's hall, she stated Resident #26 had a Bipap and used it every night. In an interview on 05/08/2025 at 2:45 pm with LVN B, who was the nurse who admitted Resident #26, she stated she did not know Resident #26 had a Bipap machine and thought someone may have brought it into the facility for her the next day. She stated she was aware Resident #26 used Bipap at night but was not aware there was not a physician's order. She did not know how it was missed. She stated nursing staff provided care IAW physician orders. She did not know how it was missed. She stated IAW professional standards of practice, a physician's order was required for treatments such as a Bipap. She stated the wrong settings could cause too little or too much supplemental oxygen and result in discomfort. Review of the facility policy and procedure titled Physician Orders revised January 2020 reflected Physician orders include b. Treatments, Medications, diets, therapy, or any treatment may not be administered to the patient without a written order from the attending physician.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview, and record review the facility failed to ensure correct use of bed rails and to assess the resident for risk of entrapment from bed rails for 3 of 6 Residents observed for the use of side rails (Resident #1, Resident #13 and Resident #340). 1. Nursing staff failed to obtain an informed consent and assess Resident's #1 for the use of 1/4 side rails. 2. Nursing staff failed to obtain an informed consent for Resident #13 for the use of 1/4 side rails. 3. Nursing staff failed to obtain an informed consent and to assess Resident #340 for the use of 1/4 side rails. These deficient practices could affect any resident with bed side rails and could cause avoidable accidents. The findings were: 1. Review of Resident #1's quarterly MDS assessment, dated 12/13/24 revealed he was admitted to the facility on [DATE] with diagnosis including non-traumatic brain dysfunction. His BIMS score was 12 of 15 reflective of moderate cognitive impairment and he required substantial to maximum assistance with bed mobility; roll left and right. Review of Resident #1's document for Assist Rail/Enabler Device: Informed Consent, dated 3/21/24 was not signed by either the Patient or Patient Representative. Review of Resident #1's physician orders for May 2025 revealed an order Quarter assist rails in place as an enabler as desired or needed. Alert MD of any noted complications of Quarter Assist Rail use. PR aware and in agreement with use. No directions specified for order. Other Active 3/20/2025. Review of Resident #1's Care Plan initiated 4/8/25 revealed Patient uses quarter assist rails(s)as enabler to assist with bed mobility and transfer. [Specify]: Assist Rail x 1 Left) Assist Rail x 1, (Right)Assist Rails x 2 Assist Rail(s) - Quarter Rail(s) required as enabler in order to promote as much independence as possible. Resident will be free of entrapment and injury while using quarter assist rail(s) as an enabler for the next 90 days. Complete Assist Rail/ Enabler Device assessment to determine appropriate use. Obtain Consent Assess prn with Change of Condition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado at Stone Oak	19638 Stone Oak Parkway San Antonio, TX 78258

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/08/25 at 02:15 PM revealed Resident #1 lying in bed on an air mattress. There were wedges between 1/4 SR and the mattress on both sides of the bed. Interview with Resident #1 revealed he was doing well. He stated the wedges between the mattress and SR were used to keep him upright. He stated he did not use the side rail and commented could put a rope through it. and then commented would both get tangled up. Resident #1 stated staff would get him up out of bed. Resident #1 presented as being pleasantly confused. Interview on 05/08/25 at 03:25 PM with LVN/Unit Manager D revealed Residents who used side ails required a consent and assessment for use of side rails. She stated Resident #1 used 1/4 side rails but had experienced a decline in mentation/overall condition in the last several months. She stated Resident #1 was able to hold on to the side rails but was not able to use them for bed mobility. He required total assistance for bed mobility and repositioning. The ADON stated at this point the side ails would not be beneficial for Resident #1. The ADON stated nursing staff should re-assess Residents every 3 months for the use of side rails to ensure they could use the side rails safely to avoid accidents. She commented, that's my fault because I haven't done it; reassessed Resident #1. Unit Manager D stated she was responsible for ensuring Residents were assessed every 3 months. Further interview revealed, upon reviewing Resident #1's informed consent, it was not signed it; therefore, the consent was not valid. She stated it had to be signed and in place prior to the use of side rails. 2. Review of Resident #13's face sheet, dated 5/9/25, revealed she was admitted to the facility on [DATE] with diagnosis including unspecified Dementia. Review of Resident #13's re-entry MDS, dated [DATE], revealed her BIMS score was 10 of 15 reflective of moderate cognitive impairment and she required she required partial to moderate assistance by staff for bed mobility; roll left and right. Review of Resident #13's Care Plan initiated 4/8/25 revealed Patient uses quarter assist rails(s)as enabler to assist with bed mobility and transfer. [Specify]: Assist Rail x 1 Left) Assist Rail x 1, (Right)Assist Rails x 2 Assist Rail(s) - Quarter Rail(s) required as enabler in order to promote as much independence as possible. Resident will be free of entrapment and injury while using quarter assist rail(s) as an enabler for the next 90 days. Complete Assist Rail/ Enabler Device assessment to determine appropriate use. Obtain Consent Assess prn with Change of Condition. Review of Resident #13's document for Assist Rail/Enabler Device: Informed Consent, dated 12/13/24 was not signed by either the Patient or Patient Representative. Interview on 05/08/25 at 03:25 PM with Unit Manager D revealed, upon reviewing Resident #13's informed consent, the family representative had not signed it; therefore, the consent was not valid. She stated it had to be signed and in place prior to the use of side ails. 3. Review of Resident #340's face sheet, dated 5/9/25, revealed he was admitted to the facility on [DATE] with diagnoses including unspecified Dementia and Unspecified Fracture Of Left Femur, Subsequent Encounter for closed fracture with routine healing, (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #340's initial assessment, dated 5/3/25, revealed he required assistance with bed mobility: c. Limited to extensive assist- assist x1-2. Intervention: BED MOBILITY: The resident requires assistance x1 or x2 staff to turn and reposition in bed. This may fluctuate with weakness and fatigue.' Review of Resident #340's BIMS assessment, dated 5/7/25, revealed his score was 9 of 15 reflective of moderate cognitive impairment. Review of Resident #340 electronic health record revealed there was not a consent or assessment for the use of 1/4 side rails. Observation and interview on 05/06/25 at 11:37 AM revealed Resident #340 lying in bed watching TV. Noted 1/4 side rails were up on both sides of the bed. Resident #340 stated staff helped him reposition in bed and he would hold on to the side rails. Interview on 05/08/25 at 03:25 PM with Unit Manager D revealed an informed consent had not been obtained for the use of side rails for Resident #340. She stated nursing staff had also not assessed Resident #340 to ensure he was safe to use the side rails. Review of facility policy, Proper Use of Side Rails, undated, revealed Purpose: The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility. b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet. c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident care plan.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review the facility failed to ensure the residents were seen by a physician at least at least once every 60 days for 2 of 6 Residents (Resident #2 and Resident 92) whose records were reviewed for physician visits. 1. The facility failed to ensure Resident #2's primary care physician met with Resident #2 as required. 2. The facility failed to ensure Resident #92's primary care physician met with Resident #92 as required. This deficient practice could affect any resident and could contribute to the resident's medical needs not being addressed or met. The findings were: 1. Review of Resident #2's face sheet, dated 5/9/25, revealed he was admitted to the facility on [DATE] with diagnoses including Epilepsy and personal history of Traumatic Brain Injury. Review of Resident #2's quarterly MDS assessment, dated 4/14/25, revealed his BIMS was 11 of 15 reflective of moderate cognitive impairment. Review of Resident #2's electronic health record including physician progress notes from December 2024 to May 2025 revealed there was no documentation from the PCP that he had visited Resident #2 for the last 6 months. Review of Resident #2's last health visit, dated 2/26/25, revealed a FNP had seen him. Interview with the DON on 05/09/25 01:50 PM revealed she did not find documentation to support Resident #2's primary care physician had seen Resident #2 most recently. She provided a progress note from a FNP, dated 2/26/25, and stated it was the last heath visit for Resident #2. The DON stated she did not believe there was a potential for a negative outcome because the NP visited regularly, However, stated she understood the primary care physician was ultimately responsible for Resident #2 healthcare and had an obligation to see Resident #2 at least every 60 days. 2. Review of Resident #92's significant MDS assessment, dated 4/15/25, revealed she was admitted to the facility on [DATE] with diagnoses including, Cancer and CVA (Cerebral Vascular Accident), her BIMS was 15 of 15 reflective she did not have cognitive impairment. Review of Resident #92's electronic health record including physician progress notes from December 2024 to May 2025 revealed there was no documentation from the PCP that he had visited Resident #92 for the last 6 months. Review of Resident #92's last health visit, dated 2/26/25, revealed a FNP had seen her. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 05/09/25 01:50 PM revealed she did not find documentation to support Resident #92's primary care physician had seen Resident #92 most recently. She provided a progress note from a FNP, dated 2/26/25, and stated it was the last heath visit for Resident #92. The DON stated she did not believe there was a potential for a negative outcome because the NP visited regularly, However, stated she understood the primary care physician was ultimately responsible for Resident #92 healthcare and had an obligation to see Resident #92 at least every 60 days. Review of facility policy, Physician Visits revised April 2013, revealed The attending physician must make visits in accordance with applicable state and federal regulations. 1. The attending physician [NAME] visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone. 2. The attending physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622 Based on observations, interview, and record reviews, the facility failed to provide pharmaceutical services to administer drugs and biologicals that meet the needs of each resident for 2 of 5 medication carts (Cart #1 and #2 on 800 hall) observed and for 1 of 2 medication rooms ([NAME] Hall) observed. 1.The facility failed to remove expired medications from medication cart #1 and medication cart #2 on the 800 hall. 2. The facility failed to remove expired medication from the medication room on the [NAME] hall. These failures could place residents at risk of decreased therapeutic response and illness from expired medications. The findings included: Observation of the medication rooms on 5/7/2025 at 9:45AM revealed the [NAME] Unit medication room had an open box of Preparation H with a label expiration date of 5/2024. Observation of medication carts on 5/7/2025 at 10:00AM revealed medication carts #1 had 5 over the counter medications that were opened and were used. Record review of the 5 labels revealed the dates were expired: 1. Geridryl 25mg had a label expiration date of 1/2025; 2. Meclizine 12.5mg had a label expiration date of 2/2025; 3. Glucosamine Relief 500mg had a label expiration date of 1/2025; 4. Heart Burn Relief (Famotidine 20mg) had a label expiration date of 11/2024 and; 5. Aspirin 325mg had a label expiration date of 2/2025. Observation of medication cart #2 revealed 1 over the counter expired medication- Sodium Bicarbonate had a label expiration date of 2/2025. Interview on 5/9/2025 at 1:04PM the DON said expired medications may not be effective, could interact with other medications in a negative way, and could cause residents to become ill if they took expired medications. She said expired medications should not be on the carts or in the medication room for administration. Record review of the facility policy statement titled Storage of Medications revised April 2007 stated, The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observations, interviews and record reviews, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 2 (Residents #26 and #293) of 32 residents observed for medication safety and security. 1. The facility failed to store Resident #26's Flonase (allergy nasal spray) in the medication cart and the medication was left on Resident #26's bedside table. 2. The facility failed to store Resident #293's Flonase (allergy nasal spray) in the medication cart and the medication was left on Resident #293's bedside table. These failures could result in , access to medications by unauthorized persons, and could result in decreased health response or misuse of medication. The findings included: 1. Record review of Resident # 26's EMR and face sheet dated 05/07/2025 reflected she was admitted to the facility on [DATE]. Her diagnoses included: displaced bicondylar fracture of right tibia (the shinbone is broken in two parts affecting both the medial and lateral bumps and the fragments are out of alignment), diabetes (a chronic condition where the body either does not produce enough insulin or cannot use the insulin it produces), morbid obesity (a severe form of obesity defined by a body mass index of 40 or higher with related health complications), allergic rhinitis (an allergic reaction that causes inflammation in the nasal passages and other symptoms like sneezing, runny nose, and itchy eyes) and shortness of breath (difficulty breathing or feeling of not getting enough air) Record review of Resident #26's admission MDS assessment dated [DATE] reflected she was admitted from a short-term general hospital. She could understand others and be understood. She scored a 15/15 on her BIMS which signified she was cognitively intact. She had impairment of her upper extremity but could ambulate with a walker. Resident #26 required moderate assistance from staff with her ADLs. She was continent of bowel and bladder. Record review of Resident #26's comprehensive care plan date initiated 04/23/2025 and revised on 05/02/2025 reflected Focus, resident has an ADL self-care performance deficit r/t GENERALIZED WEAKNESS. Record review of Resident #26's Order Summer Report, Active as of: 05/07/2025 reflected Flonase Allergy Relief Nasal Suspension 50 MCG/ACT, 2 sprays in both nostrils two times a day related to Allergic Rhinitis. The active date on the order was Resident #26's admitted [DATE]. Record review of Resident #26's MAR reflected Resident #26 received Flonase each day at 08:00 am. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/06/2025 at 11:00 am revealed Resident #26 in her room lying in bed. A prescription bottle of Flonase was on her bedside table. In an interview on 05/06/2025 at 11:03 am with Resident #26, she stated the nurse left the Flonase at her bedside and then the nurse would place the Flonase in her top dresser drawer. She stated she gave herself the nasal spray with the nurse present. Observation on 05/07/2025 at 10:00 am of Resident #26 in her room revealed her lying on her bed. There was no Flonase on her bedside table. In an interview on 05/07/2025 at 4:15 pm with Resident #26, she stated her nurse placed the prescribed Flonase in her top dresser drawer. Observation on 05/07/2025 at 4:15 pm revealed a bottle of prescribed Flonase was inside of Resident #26's top dresser drawer. Record review of the prescribed Flonase bottle located in Resident #26's top dresser drawer reflected the medication was prescribed for Resident #26. In an interview on 05/07/2025 at 4:30 pm with the DON in her office, she stated Resident #26' s Flonase was supposed to be locked in the medication cart because she did not have an order to keep it in her room or to self-medicate. She stated she was accountable for the nursing care at the facility, and nurses are trained not to leave medications at the bedside or store them in a resident's room. She stated the resident could use too much of the medication and have health complications or someone else could have access to the medication. In an interview on 05/08/2025 at 12:10 pm with LVN A revealed Resident #26's Flonase was at the resident's bedside the whole week she had worked. She stated she assumed Resident #26 could self-medicate, but never checked the resident's records or physician orders. She stated she was trained not to leave medications at the bedside because they would be available to others, or the resident could use too much causing harm. She stated she placed Resident #26's Flonase in the top dresser drawer in her room to keep it out of sight of others, and so the resident could not get it. 2. Record review of Resident #293's EMR, electronic face sheet dated 05/08/2025 reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: hemiplegia and hemiparesis (neurological conditions resulting from stroke or other brain damage, affecting one side of body. Hemiplegia is complete paralysis, while hemiparesis is weakness or impaired movement.) following cerebral infarction, (a type of stroke where blood supply to the brain is disrupted) acute respiratory failure with hypoxia (a condition where the lungs fail to adequately transfer oxygen into the blood, leading to low oxygen levels and potentially tissue hypoxia), diabetes mellitus (a chronic metabolic disorder characterized by persistently high blood sugar levels), neuromuscular dysfunction of bladder (arises from damage or malformation of nerves controlling the bladder) and allergic rhinitis (an allergy that causes inflammation of the nose and nasal passages). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #293's admission MDS assessment dated [DATE] reflected she could understand others and be understood. She scored a 06/15 on her BIMS which signified she was severely cognitively impaired. She used a walker or manual wheelchair for locomotion. Resident #293 required extensive assistance with ADLs. She had shortness of breath and trouble breathing when lying flat. She received oxygen therapy while at the facility. Record review of Resident #293's comprehensive care plan initiated on 04/25/2025 and revised on 05/06/2025 reflected Focus, resident has an ADL, self-care performance deficit r/t GENERALIZED WEAKNESS. Record review of Resident #293's Order Summer Report, Active as of: 05/08/2025 reflected Fluticasone Propionate Suspension 50 MCG/ACT, 1 spray in both nostrils two times a day related to Allergic Rhinitis. The active date on the order was Resident #293's initial admitted [DATE]. Record review of Resident #293's MAR reflected Resident #293 received Flonase each day at 08:00 am. Observation on 05/06/2025 at 11:10 am revealed Resident #293 in her room lying in bed. Oxygen was infusing via nasal canula. A prescription bottle of Flonase was on her bedside table. Interview on 05/06/2025 at 11:11 am with Resident #293, she stated the nurse left the Flonase at her bedside and then the nurse would place the Flonase in her top dresser drawer. Observation on 05/07/2025 at 4:17 pm revealed a bottle of prescribed Flonase was inside Resident #293's top dresser drawer. Record review of the prescribed Flonase bottle located in Resident #293's top dresser drawer reflected the medication was prescribed for Resident #293. Interview on 05/07/2025 at 4:30 pm with the DON in her office, she stated Resident #293' s Flonase was supposed to be locked in the medication cart because she did not have an order to keep it in her room or to self-medicate. Interview on 05/08/2025 at 12:10 pm with LVN A revealed Resident #293's Flonase was at the resident's bedside the whole week she had worked. She stated she assumed Resident #293 could self-medicate, but never checked the resident's records or physician orders. She stated she placed Resident #293's Flonase in the top dresser drawer in her room to keep it out of sight of others. Record review of the facility policy statement titled Storage of Medications revised April 2007 reflected The facility shall store all drugs and biologicals in a safe, secure, and orderly manner .the nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observation, interviews and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 resident (Resident #294) of 32 residents reviewed for EBP. The facility failed to establish EBP for Resident #294 when she had an open sacral wound with a dressing. This facility failure affects residents with open wounds, or other requirements for EBP, and could result in MDRO contamination. The findings included: Record review of Resident #294's EMR, electronic face sheet dated 05/03/2025 reflected she was admitted to the facility on [DATE]. Her diagnoses included: fracture of upper end of right humerus (break or crack in the bone located at the upper part of the arm near the shoulder joint), fracture of lower end of left radius (bone in forearm breaks near the wrist joint), chronic kidney disease (moderate decrease in kidney function), diabetes mellitus (group of diseases that affect how the body uses blood sugar) and edema (swelling caused by excess fluid trapped in the body's tissues). Record review of Resident #294's EMR revealed Resident #294 was not at the facility long enough for an admission MDS assessment. Record review of Resident #294's comprehensive care plan initiated on 05/03/2025 reflected Focus, resident has a pressure ulcer, Interventions, administer treatments as ordered and monitor for effectiveness. Record review of Resident #294's Active Orders As of: 05/09/2025 reflected Right Buttock, Stage 3, cleanse with wound cleaner/Ns, pat dry. Apply triad (unique wound care product that combines the benefits of a protective ointment and a moisture barrier cream. This cream is zinc oxide based). to affected area, and cover with DD, day shift, Monday, Wednesday, and Friday for Sacrum (a triangular bone at the base of the spinal column that connects with or forms a part of the pelvis), The wound order was dated 05/05/2025. Record review of the facility pressure sore log dated 05/07/2025 reflected Resident #294 had a Stage III pressure sore to the sacrum and date of onset was 05/03/2025 her day of admission. Record review of Resident #294's TAR dated May 2025 reflected she received the ordered wound treatment for her sacrum on Monday, 05/05/2025 and Wednesday, 05/07/2025. Observation on 05/09/2025 at 11:30 am of Resident #294's wound care to her sacrum provided by the Treatment Nurse. Prior to entering Resident #294's room, the surveyor questioned the TX nurse why Resident #294 did not have EBP in place because she had a wound with a dressing. No signage was seen on her door and no bin was present by her room with PPE. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/2025 at 11:32 am with the TX Nurse, she stated Resident #294's wound did not have drainage, and she did not know open wounds with dressings required EBP. Record review of an EBP sign on a door across the hall from Resident #294's room for a resident on EBP reflected: STOP, ENHANCED BARRIER PRECAUTIONS, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities .Wound Care any skin opening requiring a dressing. Interview on 05/09/2025 at 4:30 pm with the DON revealed she was not aware Resident #294 was not on EBP because of her open wound which required a dressing. She stated staff was trained and she felt the facility overall did a great job and recognized residents who needed to be on EBP. She stated EBP was important to prevent cross contamination or development of MDROs for susceptible residents with open skin areas. Record review of staff in-service on EBP dated 3/19/2025 reflected the Treatment Nurse received training that covered the need for signage and precautions. Record review of the facility policy statement titled Enhanced Barrier Precautions dated August 2022 reflected Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents,.EBPs are indicated with the following: Wound care (any skin opening requiring a dressing).