STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Retirement Community	4100 Moores LN Texarkana, TX 75503

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, record review, and interview, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 2 of 12 residents reviewed for resident rights. (Resident #7 and Resident #182) The facility failed to protect and promote the rights of Resident #7 and Resident #182 by not knocking on the room door prior to entering the resident's room. This failure could place residents at risk for decreased privacy and decreased quality of life. The findings included: 1. Record review of an undated face sheet revealed Resident #7 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of CHF (impairment of the heart to pump blood sufficiently), Diabetes Mellitus Type II (prolonged high levels of glucose in the blood), and dementia (a group of symptoms affecting the memory). Record review of an admission MDS assessment dated [DATE] revealed Resident #7 had a BIMS of 00 which indicated a severe cognitive impairment. Resident #7 was dependent for ADL's such as toileting, transfer, and bathing. Resident #7 had 1 fall with no injury and was taking daily antidepressants. During an observation on 11/04/2024 at 9:20 a.m. revealed CNA C entered Resident #7's room without knocking. During an observation on 11/04/2024 at 12:15 p.m., revealed CNA C entered Resident #7's room without knocking. During an interview on 11/04/2024 at 10:00 a.m., Resident #7's family member stated he had been a witness to the CNAs not knocking on the door several times. He stated just this morning, CNA C came in twice and never knocked. Resident #7's family member stated Resident #7 was a private person and prior to being diagnosed with dementia she was vocal about not barging into a room without announcing themselves. He stated he felt she would be upset by the caregivers not knocking. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of an undated face sheet revealed Resident #182 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of CHF (inability of the heart to pump effectively), kidney failure (inability of the kidney to filter correctly), and Dementia (a group of symptoms affecting the memory). Record review of an admission MDS set for 11/06/2024 for Resident #182 reflected an incomplete MDS. Record review of Resident #182's baseline care plan dated 10/31/2024 had no information about dignity or knocking on the door. During an observation and interview on 11/04/2024 at 12:20 p.m., revealed Resident #182's family member told CNA C, You need to knock before you enter this room. Resident #182 agreed and stated, Yes, please knock before you come in, so I know someone is there. Resident #182 stated he inspected hospitals for years and knew it was the right of the resident for the help to knock before they entered. He stated he was not angry with or upset because she failed to knock. He stated he would have just felt better knowing she was there before she was right next to him. During an interview on 11/04/2024, CNA C stated she was aware she should knock before entering the rooms. She stated she knocked at the beginning of her shift on everyone's door she entered. She stated she was not sure why she had not knocked every time she entered Resident #7 and Resident #182's rooms, that she thought she had. CNA C stated she knew it was a sign of respect to knock before entering and that the facility had in-serviced on knocking just a few weeks prior. During a record review of the facility in-service binder dated 2024 revealed no in-service was noted on knocking before entering a resident's room During an interview on 11/06/2024 at 11:00 a.m., the DON stated it was the resident's right to live in home that was as close to the home they lived in prior to coming to the facility. She stated that was why knocking before entering was important. She stated no one that worked there would enter someone's home without knocking first and it was the same concept at the nursing facility. During an interview on 11/06/2024 at 2:00 p.m., the ADM stated she expected all staff to knock and provide care with dignity and respect for the elders of the community. She stated no one entered the staff's home without knocking and she wanted the staff to understand the correlation. She stated not knocking can make the resident feel less important and as if their privacy was unimportant to the facility. Review of an undated Resident Rights facility policy indicated, .Federal and state laws guarantee certain basic right to all resident in this facility. These rights include the resident's right to .a dignified existence .be treated with respect, kindness dignity . and self-determination.

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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 - Some	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** 44596 Based on observation, interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to ensure the comprehensive care plan described the services and interventions to be used to attain and maintain the resident's practicable physical, mental, and psychosocial well-being for 3 (Resident #7, Resident #15, and Resident #28) of 12 residents reviewed for care plans. 1. The care plans for Resident #7 had interventions for daily weights, fall mats on both sides of the bed, and a Velcro heel protector to the left heel while in bed that were not being implemented. 2. The care plan for Resident #15 had interventions for daily weights that were not being implemented. 3. The care plans for Resident #28 had interventions for fall mats at bedside and eating each meal in the dining room related to a history of weight loss that were not implemented. These failures could place residents at risk of not having their individualized needs met, falls, weight loss and a decline in their quality of care and life. 1. Record review of an undated face sheet revealed Resident #7 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of congestive heart failure (impairment of the heart to pump blood sufficiently), Diabetes Mellitus Type II (prolonged high levels of glucose in the blood), and dementia (a group of symptoms affecting the memory). Record review of an admission MDS assessment dated [DATE] revealed Resident #7 had a BIMS of 00 which indicated a severe cognitive impairment. Resident #7 was dependent for ADL's such as toileting, transfer, and bathing. Resident #7 had 1 fall with no injury and was taking daily antidepressants. Record review of a care plan dated 08/23/2024 titled Hydration reflected Resident #7 had poor fluid maintenance related to CHF with an intervention of monitoring her weight per MD orders. Record review of a care plan dated 08/23/2024 titled Fall prevention reflected Resident #7 had a history of falls and had an intervention of fall mats on both sides of bed while the resident was in bed. Record review of a care plan dated 08/23/2024 titled Skin Impairment reflected Resident #7 had a history of pressure ulcers to her left heel and an intervention was to have a Velcro boot to her left heel when in bed. Record review of the consolidated physician's orders dated 11/05/2024 indicated an order for Resident #7 to be weighed daily with the lift to monitor CHF started on 08/23/2024. Record review of Resident #7's weight log indicated the following days Resident #7 had not been weighed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/18/2024, 09/19/2024 09/23/2024 09/24/2024 09/26/2024 09/27/2024 09/28/2024 09/29/2024 10/02/2024 10/03/2024 10/06/2024 10/07/2024 10/08/2024 10/09/2024 10/11/2024 10/12/2024 10/13/2024 10/14/2024 10/17/2024 10/20/2024 10/21/2024 10/24/2024 10/25/2024 10/28/2024 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/30/2024 During an observation on 11/04/2024 8:45 a.m. revealed Resident #7 was lying in bed with 1 fall mat at the foot of her bed and 1 fall mat propped against the wall by the window. Resident #7 was not wearing a heel protector boot. During an observation on 11/04/2024 10:15 a.m. revealed Resident #7 was lying in bed with 1 fall mat at the foot of her bed and 1 fall mat against the wall by the window. Resident #7 was not wearing a heel protector boot. During an observation on 11/05/2024 10:07 a.m. revealed Resident #7 was lying in bed with 1 fall mat at the foot of her bed and 1 fall mat against the wall by the window. Resident #7 was not wearing a heel protector boot. 2. Record review of an undated face sheet revealed Resident #15 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of atrial fibrillation (irregular heartbeat), anxiety and dementia (a group of symptoms affecting the memory). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #15 had a BIMS of 03 which indicated a severe cognitive impairment. Resident #15 required moderate assistance for ADL's such as toileting, transfer, and bathing. Record review of a care plan dated 07/08/2024 titled Hydration reflected Resident #15 had poor fluid maintenance related to CHF with an intervention of monitoring weight per MD orders. Record review of the consolidated physician's orders dated 11/05/2024 indicated an order for Resident #15 to be weighed daily with the lift to monitor CHF started on 08/23/2024. Record review of Resident #15's weight log indicated the following days Resident #15 had not been weighed: 09/18/2024 09/19/2024 09/23/2024 09/24/2024 09/26/2024 09/27/2024 09/28/2024 09/29/2024 10/02/2024 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/03/2024 10/06/2024 10/07/2024 10/08/2024 10/09/2024 10/11/2024 10/12/2024 10/13/2024 10/14/2024 10/17/2024 10/20/2024 10/21/2024 10/24/2024 10/25/2024 10/28/2024 10/30/2024 3. Record review of an undated face sheet revealed Resident #28 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of anemia (low iron in the blood), Diabetes Mellitus Type II (prolonged high levels of glucose in the blood), and dementia (a group of symptoms affecting the memory). Record review of an admission MDS assessment dated [DATE] revealed Resident #28 had a BIMS of 00 which indicated a severe cognitive impairment. Resident #28 was dependent for ADL's such as toileting, transfer, and bathing. Record review of Resident #28's care plan on 11/05/2024 titled fall risk revealed an intervention for fall mats to be used when the resident was in bed. Record review of Resident #28's care plan on 11/05/2024 titled weight fluctuation revealed an intervention that Resident #28 was to be out of the bed and eat in the dining room for all meals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/06/2024 at 10:00 a.m., RN E stated care plans were to be followed by CNAs and nurses. She stated the care plan was the blueprint directions for individualized resident care. She stated it was the responsibility of the floor nurse to communicate all the needs of the residents to the CNAs. She stated the floor nurses should look at the EHR and the rooms to makes certain all interventions for resident concern areas are being implemented. She stated not implementing the care plans could cause the resident to not be protected from falls, disease process, and weight fluctuation. She stated all nurses and CNAs have access to the care plans through the documentation system. During an interview on 11/06/2024 at 11:00 a.m., the DON stated it was the floor nurse and the administration nurses' responsibility to ensure that staff was educated about interventions for falls, disease processes and weight loss. She stated without interventions preventing falls and exacerbation in disease process would not be possible and could lead to resident harm. During an interview on 11/06/2024 at 2:00 p.m., the ADM stated she expected the staff to follow the interventions decided on by the MDS Coordinator and interdisciplinary team. She stated the interventions were in place to keep everyone safe and prevent accidents. She stated not following the interventions could decrease the resident's quality of life. Record review of a facility policy undated titled 'Comprehensive Care Planning revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . The facility will establish, document, and implement the care and services to be provided for each resident to assist in attaining or maintaining his or her highest practical quality of life.

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview and record review the facility failed to ensure a central venous line site was maintained consistent with professional standards of practice for 1 of 1 residents reviewed for central venous lines (a thin, flexible tube that's inserted into a large vein to provide access to the circulatory system). (Resident #18) The facility failed to change a midline catheter (a type of central venous line) dressing according to facility protocol causing Resident #18 to miss one dressing change. The area was observed to be red and warm to the touch. The resident developed a localized midline infection at the site that was confirmed by the Nurse Practitioner. Resident #18 was sent to the hospital for replacement of the midline catheter. This failure resulted in the identification of an Immediate Jeopardy (IJ) on 11/05/24 at 1:15 p.m. The IJ template was provided to the facility on [DATE] at 1:22 p.m. While the IJ was removed on 11/06/24 at 10:48 a.m., the facility remained out of compliance at a scope of isolated and a severity level at potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents with central venous lines at risk of a systemic infection that could lead to serious illness and/or death. Findings included: Record review of a face sheet dated 11/04/2024 revealed Resident #18 was a [AGE] year-old male and was readmitted on [DATE] with diagnoses including urinary tract infection, carrier of carpenium-resistant enterobacterales (a group of bacteria that are resistant to antibiotics and can cause serious infections), and pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus, making it difficult to breathe). Record review of an annual MDS dated [DATE] revealed Resident #18 was understood and understood others. The MDS revealed a BIMS score of 12, indicating moderate cognitive impairment. The MDS indicated Resident #18 required partial to moderate assistance with ADL's. The MDS indicated Resident #18 received IV (intravenous medications) while a resident. Record review of a care plan last revised on 10/28/24 revealed Resident #18 on the intravenous medication Avycaz related to carpenium-resistant enterobacterales. There was an intervention of PICC LINE (a type of central venous line) DRESSING: Left upper, are, observe dressing daily and change per orders. Record review of a hospital Physician Discharge Summary dated 10/24/24 at 8:31 a.m. indicated Resident #18 had been admitted to the hospital on 10/19/24 and was discharged on [DATE]. There was a diagnosis of Sepsis (a life-threatening condition that occurs when the body has an extreme response to an infection or injury) secondary to UTI (urinary tract infection). (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #18 electronic medical record from 10/24/24 - 11/03/24 did not indicate documentation of a central venous line dressing change or assessment of the site to Resident #18's left upper arm. Record review of a physician's order summary report for Resident #18 dated 11/04/24 did not indicate a physician's order for central venous line care, including dressing changes. There was an order for Avycaz Intravenous Solution Reconstituted 2.5 (2-0.5) grams (an antibiotic medication used to treat a wide variety of bacterial infections), use 2.5 gram intravenously three times a day for CRE until 11/06/2024. During an observation on 11/04/24 at 10:04 a.m., revealed Resident #18 had a single lumen (a single catheter) central venous line to the resident's left upper arm. The transparent dressing was dated 10/24/24. Record review of a nursing progress note for Resident #18 dated 11/04/24 at 6:45 p.m., indicated .Nurse was called to elder room @ 1300 (1:00 p.m.) Elder sitter informed nurse of some warm redness to left arm elder denies any pain, discomfort, or itching, (Nurse Practitioner) was informed and gave orders to have midline removed and a new one replaced and to start Bactrim DS po BID (by mouth twice a day) x 7 days. Elder informed and [family member] was informed also elder refused to have removal done this evening time 3-4 offers. Elder claims he was not mentally prepared and would like to wait until morning once sent to ER (emergency room) . Record review of a nursing progress note for Resident #18 dated 11/04/24 at 6:56 p.m., indicated Elder currently has IV ABT (intravenous antibiotic on hold until order given to resume with current or new midline. Record review of a Nurse Medication Administration Record dated 11/01/24 - 11/06/24 indicated Resident #18 did not receive Avycaz Intravenous Solution 2.5 grams for three scheduled doses for 11/05/24 due to the medication being on hold. During an observation and interview on 11/05/24 at 7:50 a.m., revealed Resident #18 had a single lumen (a single catheter) central venous line to the resident's left upper arm. The transparent dressing was dated 10/24/24. There site was red, and the redness extended under Resident #18's arm outside of the dressing. RN E said Resident #18 was being sent to the hospital due to redness and the site being warm to the touch. She said he was not going to the emergency room . She said the Nurse Practitioner had been notified and the resident had been placed on oral antibiotics. She said central venous line dressings were to be changed every 7 days. During an interview on 11/05/24 at 8:53 a.m., the Nurse Practitioner said Resident #18 had a localized midline (central venous line) infection. She said staff attempted to remove the central venous line on 11/04/24 and he refused to have it pulled. She said he was scheduled to have it replaced at 1:30 p.m. on 11/05/24. She said the site around the central venous line was red and warm to the touch. She said she expected the facility to follow central venous line dressing protocol on dressing changes. She said typically the dressing change order would be put in the admission orders. She said she would have expected the dressing to have been changed before now. She said the dressing not being changed could contribute to an infection. She said Resident #18 did pick at his dressing and the site. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 11/05/24 at 10:20 a.m., revealed Resident #18 had a single lumen (a single catheter) central venous line to the resident's left upper arm. The transparent dressing was dated 10/24/24. The site was red, and the redness extended under Resident #18's left arm outside of the dressing. Resident #18 said the area was tender. Record review of physician's orders dated 11/05/24 indicated, .may have PICC (a type of central venous line) line removed per (Nurse Practitioner). PICC appears warm to touch with redness noted and Remove midline from Left upper extremity. Send out for replacement midline. Record review of a nursing progress note for Resident #18 dated 11/05/24 at 10:36 a.m. indicated, Midline removed per (Nurse Practitioner). Removal of midline was guided by CDC recommendations. Elder tolerated well .Elder will be seen today at (hospital) for replacement. Record review of a Vascular Access Team - Report of Procedure dated 11/05/24 at 2:00 p.m. indicated, Procedure orders - Insert Midline . The report indicated a midline was inserted on 11/05/24 at 3:33 p.m. to right basilic (vein in upper right arm). Record review of a physician's order summary report for Resident #18 dated 11/06/24 indicated an order with a start date of 11/05/24 for Bactrim DS Oral Tablet (antibiotic used to treat infection) 800-160 milligrams, give 1 tablet by mouth two times a day for possible phlebitis (a condition where a vein becomes inflamed and could be caused by infection, injury, or irritation) for 7 days. The order for Avycaz Intravenous Solution was on hold. During an interview on 11/05/24 at 11:08 a.m., the DON said the central venous line site should have been observed with every encounter and dressing changed every 7 days. She said there should be documentation of the dressing change. She said Resident #18's central venous line dressing change should have been done on 10/31/24 . She said a central venous line dressing not being changed could lead to infection. During an interview on 11/05/24 at 12:06 p.m., the DON said the nurse admitting a resident should get an order for dressing changes. She said there should be an order so that everyone knew there should be a dressing change and when it is due to be changed. She said the nurse that admitted Resident #18 should have put in orders for central line dressing changes. During an interview on 11/05/24 at 12:10 p.m., RN E said the admitting nurse should obtain an order for a dressing changes. She said that then placeds an order on the nursing medication administration record or the treatment administration record. During an interview on 11/06/24 on 8:47 a.m., RN F She said she was the admitting nurse for Resident #18 on 10/24/24. She said if a resident was admitted with a central venous line the admitting nurse was supposed to put the order in for dressing changes and care. She said she overlooked putting in an order for Resident #18's central venous line care. She said there were a lot of things with that admission that got her sidetracked. She said Resident #18 got antibiotics three times a day and she said she did not understand why other nurses did not notice his dressing needed to be changed. She said a dressing not being changed could lead to infection. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/06/24 at 10:09 a.m., the ADON said she would have expected for orders to have been placed for the central venous line dressing change and care for Resident #18. She said this was the responsibility of the admitting nurse. She said the dressing should have been changed on 10/31/24. She said there was always potential for infection if the central venous line dressing change was not done. During an interview on 11/06/24 at 1:27 p.m., the Administrator said the admission nurse should have put an order in for a central venous line dressing change for the appropriate time per their policy. She said a dressing not being changed in a timely manner could cause an infection. Record review of a Central Venous Catheter Care and Dressing Changes facility policy dated March 2022 indicated, .The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings .A physician's order is not needed for this procedure .Change the dressing if it becomes damp, loosened or visibly soiled and .at least every 7 days for TSM dressing (a transparent semi-permeable membrane dressing) .Assess central venous access devices with each infusion and at least daily .check expiration dates of the infusion, dressing, and administration set .the following information should be recorded in the resident's medical record .Date and time dressing was changed . Record review of https://www.registerednursern.com/picc-line-care-picc-line-dressing-change-clinical-nursing-skills/ accessed on 11/12/24 PICC Line Care PICC Line Dressing Change Clinical Nursing Skills indicated .A peripherally inserted central catheter or PICC line is a soft plastic tube that is inserted into a large vein right above the patient's heart. The PICC line must always remain sterile so that the patient does not run the risk of getting an infection. PICC lines should be changed at least once per week. If the dressing becomes loose, wet, or dirty, the dressing must be changed more often to prevent infection. PICC line dressings must be inspected on a daily basis. Moist dressings are breeding grounds for infections . The Administrator was notified of an IJ on 11/05/24 at 1:22 p.m. and was given a copy of the IJ template and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 11/05/24 at 5:55 p.m. and included the following: Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on November 5, 2024, for failing to follow the central venous catheter care and dressing change policy by assessing, monitoring and documenting the IV daily. One resident of the facility had the potential to be affected by this alleged deficient practice. A. Corrective Action Notified PCP. Removed Resident #18's PICC line on 11/5/2024. Resident #18 went to a hospital for a PICC line replacement for 11/5/2024. Ad Hoc QAPI meeting was held in Administrator's office on 11/05/2024 around 4:15PM with the following in attendance: Administrator, Medical Director, Nurse Practitioner, DON, ADON and Executive Director. Community Plan for Removal developed and initiated from this meeting. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-Service initiated on 11/5/2024 regarding Central Venous Catheter Dressing Changes. Registered Nurses will be in-serviced prior to working their next shift by the DON/ADON and/or designee. o The in-service covers the frequency of dressing changes, or when needed, to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. o Corporate Nurse, via Teams Conference call with video and audio, and Nurse Practitioner, in person, in-serviced DON and ADON on 11/5/2024. DON began in-servicing Registered Nurses via in-person and Teams Conference call via video and audio on 11/5/2024. In-service initiated on 11/5/2024 regarding Admission Check List and Documentation Guidelines for Infusion Therapy. Nurses will be in-serviced prior to working their next shift by the DON/ADON and/or designee. o The Documentation Guidelines for Infusion Therapy covers assessing, monitoring, and documenting regarding infusion therapy. o The Admission Checklist includes skin assessment, pictures of the skin and IV dressing orders. Admission Nurse will use Admission Checklist to ensure admission is correct. o Corporate Nurse, via Teams Conference call with video and audio, and Nurse Practitioner, in person, in-serviced DON and ADON on 11/5/2024. DON will begin in-servicing Nurses via in-person and Teams Conference call via video and audio on 11/5/2024. B. Identification: There is no other resident at risk, as there are no other intravenous lines at this time. C. Preventative Measures: Admission audit sheet created. Admission Nurse will use Admission Checklist to ensure admission is correct. Quality Assurance Nurse, ADON, will check behind this Admission Nurse by the next weekday morning. A Triple Check will be completed by the MDS Nurse by third weekday. D. Monitoring: DON and/or designee will monitor admissions daily for two weeks beginning on 11/6/2024 to ensure compliance. DON and/or designee will monitor admissions weekly beginning on 11/20/2024 to ensure compliance and report to the Community QAPI Committee meetings for six months unless otherwise determined by the QAPI committee. Medical Director informed of the Immediate Jeopardy on 11/5/2024. DON and/or designee will monitor Central Venous dressings biweekly beginning on 11/5/2024 to ensure dressing is clean, dry, intact and changed timely and report to community QAPI Committee meetings for six months unless otherwise determined by QAPI committee. The surveyor verification of the Plan of Removal from 11/05/24 was as follows: (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a QAPI Sign in Sheet dated 11/05/24 indicated a QAPI meeting was held on 11/05/24 and was attended by the ADON, DON, Administrator, the Nurse Practitioner, Executive Director, and Medical Director. Record review of a Resident Matrix dated 11/04/24 indicated Resident #18 was the only resident receiving intravenous therapy. Record review of a blank Admission Checklist indicated information concerning the resident being admitted including allergies, vitals, diet, completion of all evaluations due on admission, medications, skin assessment, and any customized standing orders. The customized standing orders included dressing changes, wound care or treatment orders, and pictures of skin issues. Notifying the Nurse Practitioner, ADON, and DON were part of the checklist. There was a section for the signature of the admitting nurse and the ADON. Record review of a Training In-Service form dated 11/05/24 indicated the Corporate Nurse and the Nurse Practitioner in-serviced the DON and the ADON on central venous dressing changes and the process for the Admission Checklist. Record review of Admit Checklist Training In-Service forms dated 11/05/24 indicated 9 nurses across all shifts were educated on all nurses completing an admission will be required to complete the new Admit Checklist by the end of the shift and turn into ADON for Follow up. Record review of PICC line care & dressing change Training In-service forms dated 11/05/04 indicated 17 nurses across all shifts were educated on Central Venous Catheter Dressing Changes. The in-service indicated, Change dressing if any suspicion of contamination is suspected .change transparent semi-permeable membrane (TSM) dressings at least every 7 days and PRN (as needed, when wet, soiled, or not intact). The in-service indicated the nurses were educated on documentation including date and the time the care was provided. During an interview on 11/06/24 at 10:05 a.m., the MDS Nurse said she was in-serviced by the DON concerning PICC line care & dressing changes including documentation and assessment. She said a dressing to PICC lines should be changed every 7 days and as needed if soiled or loose. She said a resident being admitted with a PICC line should be assessed by the admitting nurse. The admitting nurse should document the assessment and check to make sure all orders were in. She said she was in-serviced on new Admission Checklist. She said the ADON in-serviced her on the check list. She said the charge or admitting would complete a check list on admission. Then it would be passed to the ADON. The ADON will make sure everything has been done. She said she was then the third check. Then it would be passed to the DON. She said that would be the procedure for all new admissions. During an interview on 11/06/24 at 10:09 a.m., the ADON said she was in-serviced by the Nurse Practitioner, in house, and the Corporate Nurse via video call. She said she was in-serviced on documentation, dressing changes, and the admission checklist. She said the check list, once completed, would be brought to her so she could make sure everything was done. She said that would be on the next weekday. She said the checklist would then be passed off to the MDS nurse so that she could do an audit on the third day. She said that would be on every admission. She said there had been no admission since the form was implemented on 11/05/24. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/06/24 at 10:23 a.m., the DON said she was in-serviced by the Corporate Nurse and the Nurse Practitioner on 11/5/24. She said she was in-serviced on the policy of PICC line dressing changes and documentation, including assessment. She said she was also in-serviced on the new Admissions Checklist. She said there had been no new admissions since 11/05/24. She said the admission nurse/charge nurse would complete the check list saying they addressed those areas. The next business day the ADON would review the check list and make sure the areas were completed. The following day the MDS Nurse would do a third check. She said then the check list would be passed on to her for a 4th check. During interviews conducted on 11/06/24 beginning at 10:02 a.m. through 10:45 a.m., 15 of 21 of nurses in-serviced (the ADON, the DON, the MDS Nurse, LVN J, LVN K, RN L, RN E, RN M, LVN N, LVN P, LVN Q, LVN R, LVN S, RN T, and LVN U) were interviewed. All staff said they were educated on the newly implemented Admission Checklist. Each staff member was able to verbalize what the checklist consisted of including allergies, vitals, diet, completion of all evaluations due on admission, medications, skin assessment, and any customized standing orders, including dressing changes, wound care or treatment orders, and pictures of skin issues, notifying the Nurse Practitioner, ADON, and DON. Each nurse verbalized passing the check list off to the ADON for review and that the form would also be reviewed by the MDS Nurse. During interviews conducted on 11/06/24 beginning at 10:02 a.m. through 10:45 a.m., 17 of 21 of nurses in-serviced (the ADON, the DON, the MDS Nurse, LVN J, LVN K, RN L, RN E, RN F, RN M, LVN N, LVN O, LVN P, LVN Q, LVN R, LVN S, RN T, and LVN U) were interviewed. All staff said they were educated on central line venous care, including dressing changes every 7 days and correct documentation of the care provided. On 11/06/24 at 10:48 a.m., the Administrator was notified the IJ was removed. However, the facility remained out of compliance at a scope of isolated and a severity level at potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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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** 44128 Based on observation, interview and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 13 residents reviewed for respiratory care. (Resident #17) The facility failed to properly store Resident #17's nasal cannula while not in use by the resident. This failure could place residents at risk of respiratory complications or respiratory infection. Findings included: Record review of a face sheet dated 11/06/24 indicated Resident #17 was [AGE] years old and admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (chronic lung disease), high blood pressure, and anxiety. Record review of physician's Order Summary Report dated 11/06/24 for Resident #17 indicated an order for O2 (oxygen) via nasal cannula at 2 liters per minute with a start date of 06/05/24. Record review of the MDS dated [DATE] indicated Resident #17 usually understood others and was understood. The MDS indicated a BIMS of 00 indicating severe cognitive impairment. The MDS indicated Resident #17 received oxygen therapy while she was a resident in the facility. Record review of a care plan last revised on 09/27/24 indicated Resident #17 was at risk for complications related to COPD (chronic obstructive pulmonary disease). There was an intervention for oxygen per doctor's orders. The care plan indicated the resident required oxygen therapy. The care plan did not list interventions concerning storage of respiratory equipment. During an observation on 11/04/24 at 10:07 a.m., revealed Resident #17 was in bed. There was an oxygen concentrator beside the bed. There was a nasal cannula draped over an oxygen concentrator. The nasal cannula was touching the floor. During an observation on 11/04/24 at 2:39 p.m., revealed there was an oxygen concentrator beside Resident #17's bed. There was a nasal cannula draped over the oxygen concentrator. The nasal cannula was touching the floor. During an observation on 11/05/24 at 9:07 a.m., revealed Resident #17 was not in her room. There was an oxygen concentrator running beside the bed. There was a nasal cannula draped over the head of the bed touching the bed frame. During an observation and interview on 11/05/24 at 4:07 p.m., revealed Resident #17 was resting in bed. There was a nasal cannula in nose . The nasal cannula was attached to a running oxygen concentrator beside the bed. Resident #17 only asked for her husband and did not answer questions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/06/24 at 7:48 a.m., revealed Resident #17 was not in her room. The oxygen concentrator beside her bed was running. There was a nasal cannula attached to the concentrator. The nasal cannula was lying on the bed, touching the mattress. The bed was made. During an observation and interview on 11/06/24 at 7:50 p.m., RN E said she had seen the nasal cannula on 11/05/24 draped over the head of the bed. She said she replaced it with a new nasal cannula. A nasal cannula was observed lying on the bed touching the mattress. The bed was made. She said the nasal cannula should have been stored in a bag when it was not in use. There was a bag hanging near the head of the bed. She said when not in use the nasal cannula should be stored in the bag. She said the nasal cannula not being stored was an infection control issue. She said nursing staff was responsible for storing oxygen equipment. During an interview on 11/06/24 at 10:09 a.m., the ADON said nasal cannulas were to be stored in a bag at the head of the bed when they were not in use. She said a nasal cannula not being stored correctly could cause infection. She said there could be bacteria on the floor. During an interview on 11/06/24 at 10:23 a.m., the DON said nasal cannulas should be placed in a bag for storage when not in use. She said it should not be touching the floor. She said a nasal cannula not being stored properly could cause infection. During an interview on 11/06/24 at 1:27 p.m., the Administrator said concerning oxygen equipment storage, staff should follow policy. She said oxygen equipment should be stored in a bag when not in use. Record review of a Departmental (Respiratory Therapy) - Prevention of Infection facility policy dated November 2011 indicated, .The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment .among residents and staff .Keep the oxygen cannulae and tubing used PRN (as needed) in a plastic bag when not in use .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 46929 Based on interview and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring and appropriate diagnoses) for 4 (Residents #7, #15, #14, and #27) of 8 residents whose medications were reviewed in that: 1. The facility failed to ensure Resident #7 had an order for behavior monitoring for the two antidepressants she took daily. 2. The facility failed to ensure Resident #15 had an order for behavior monitoring for the antidepressant and two antipsychotic medications she took daily. 3. The facility failed to ensure that Resident #15's Seroquel and Zyprexa (antipsychotic medications that treats several types of mental health conditions, including schizophrenia and bipolar disorder) medication had a specific, appropriate diagnosis for use. 4. The facility failed to ensure that Resident #14 had an order for behavior monitoring for his antipsychotic and antidepressant medications. 5. The facility failed to ensure that Resident #14's Seroquel (an antipsychotic medication that treats several types of mental health conditions, including schizophrenia and bipolar disorder) medication had a specific, appropriate diagnosis for use. 6. The facility failed to ensure that Resident #27 had an order for behavior monitoring for her antianxiety and antidepressant medications . Findings included : 1. Record review of an undated face sheet revealed Resident #7 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of CHF (impairment of the heart to pump blood sufficiently), Diabetes Mellitus Type II (prolonged high levels of glucose in the blood), and dementia (a group of symptoms affecting the memory). Record review of an admission MDS assessment dated [DATE] revealed Resident #7 had a BIMS of 00 which indicated a severe cognitive impairment. Resident #7 was dependent for AD's such as toileting, transfer, and bathing. Resident #7 had 1 fall with no injury and was taking daily antidepressants. Record review of Resident #7's care plan dated 09/01/2024 titled Antidepressant revealed an intervention to monitor effectiveness every shift. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's consolidated MD orders dated November 2024 revealed she the following orders for psychotropic medications: * Zoloft 25mg once daily dated 07/01/2024. * Trazadone 50mg once daily dated 08/24/2024. Record review of Resident #7's MAR from 10/01/2024 to 10/31/2024 indicated Resident #7 took Zoloft 25mg once daily and Trazadone 50mg once daily with no behavior monitoring recorded. Record review of Resident #7's MAR from 11/01/2024 to 11/06/2024 indicated Resident #7 took Zoloft 25mg once daily and Trazadone 50mg once daily with no behavior monitoring recorded. 2. Record review of an undated face sheet revealed Resident #15 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of atrial fibrillation (irregular heartbeat), anxiety and dementia (a group of symptoms affecting the memory). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #15 had a BIMS of 03 which indicated a severe cognitive impairment. Resident #15 required moderate assistance for ADL's such as toileting, transfer, and bathing. Record review of Resident #15's care plan dated 07/01/2024 titled Antidepressant revealed an intervention to monitor effectiveness every shift. Record review of Resident #15's care plan dated 07/01/2024 titled Antipsychotic medication revealed an intervention to monitor effectiveness every shift. Record review of the consolidated MD orders dated November 2024 indicated Resident #15 had the following orders for psychotropic medications: * Fluoxetine 10mg once daily started 06/29/2024 for depression. * Olanzapine 5mg once daily started 06/28/2024 for dementia. * Quetiapine 50mg twice daily started 10/11/2024 for dementia. Record review of Resident #15's MAR from 10/01/2024 to 10/31/2024 indicated Resident #15 took fluoxetine 10mg daily, olanzapine 5mg daily, and quetiapine 50mg daily starting on 10/11/2024 with no behavioral monitoring. Record review of Resident #15's MAR from 11/01/2024 to 11/06/2024 indicated Resident #15 took fluoxetine 10mg daily, olanzapine 5mg daily, and quetiapine 50mg daily starting on 10/11/2024 with no behavioral monitoring. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #14's face sheet, dated 11/06/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included Parkinson's disease (a movement disorder of the nervous system that worsens over time), dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities), and depression (a common mental health condition that causes a persistent feeling of sadness). Record review of Resident #14's quarterly MDS assessment, dated 08/09/24, indicated he was sometimes able to make himself understood, and he was sometimes able to understand others. He had a BIMS score of 99, which indicated he was unable to complete the BIMS assessment. The assessment further indicated that he took antipsychotic and antidepressant medications. He received antipsychotic medication on a routine basis. Record review of Resident #14's care plan, last revised 10/14/24, indicated a focus of elder uses antidepressant medication. Interventions included administer anti-depressant medications as ordered by physician, and monitor/document/report adverse reactions to anti-depressant therapy. Another focus was the elder uses psychotropic medications Seroquel related to behavior management. Interventions included administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness q-shift, monitor/document/report any adverse reactions of psychotropic therapy, and monitor/record occurrence of target behavior symptoms and document per facility protocol. Record review of Resident #14's physician's orders, dated 11/06/24, indicated these orders: *Anti-depressant medication use - observe resident closely for significant side effects every shift. The start date was 06/01/24. *Anti-psychotic medication use - observe resident closely for significant side effects every shift. The start date was 06/01/24. *Seroquel oral tablet 25mg Give 0.5 tablet by mouth at bedtime for mood disorder. The start date was 09/09/24. *Zoloft tablet 50mg Give 1 tablet by mouth one time a day related to depression. The start date was 03/01/22. There was not an order that addressed behavior monitoring. 4. Record review of Resident #27's face sheet, dated 11/05/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included Parkinson's disease (a movement disorder of the nervous system that worsens over time), and dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities). Record review of Resident #27's quarterly MDS, dated [DATE], indicated she was rarely/never able to make herself understood, and she was sometimes able to understand others. A BIMS assessment was not conducted because the resident was rarely/never understood. The MDS further indicated she took an antipsychotic, antianxiety, and antidepressant medication. The resident received an antipsychotic on a routine basis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #27's care plan, last revised on 11/04/24, indicated a focus of elder uses anti-depressant medication. Interventions included administer anti-depressant medications as ordered by physician, monitor/document side effects and effectiveness every shift, and monitor/document/report adverse reactions to anti-depressant therapy. Another focus was the elder uses anti-anxiety medications. Interventions included administer anti-anxiety medications as ordered by physician, monitor for side effects and effectiveness every shift, and monitor elder for safety, the elder is taking anti-anxiety medications which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. Record review of Resident #27's physician's orders, dated 11/05/24, indicated these orders: *Anti-anxiety medication use - observe resident for significant side effects. The start date was 07/26/24. *Anti-depressant medication use - observe resident closely for significant side effects. The start date was 07/26/24. *Anti-psychotic medication - monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea/vomiting, lethargy, drooling. The start date was 07/26/24. *buspirone oral tablet 7.5mg give one tablet by mouth one time a day for anxiety related to dementia. The start date was 07/26/24. *citalopram hydrobromide tablet 10mg give one tablet by mouth one time a day for depression. The start date was 07/26/24. There was not an order that addressed behavioral monitoring. During an interview on 11/06/24 at 01:14 PM, the ADON said she expected Resident #7, Resident #15, Resident #14 and Resident #27 to have an order for behavior monitoring. She said Resident #14's Seroquel medication order should have specified a specific documented condition instead of mood disorder . During an interview on 11/06/24 at 01:28 PM, the DON said she expected Resident #7, Resident #15, Resident #14, and Resident #27 to have an order for behavior monitoring. She expected Resident #15's antipsychotic medications to have proper diagnoses and that dementia was not a proper diagnosis for antipsychotic medications. She said she expected Resident #14's Seroquel medication order to have a specific diagnosis. She said the risk to the residents for not monitoring behaviors was that they would not have supported documentation to continue the medications. During an interview on 11/06/24 at 01:43 PM, the Administrator said she expected the staff to follow the facility policy and the DON's guidance for behavior monitoring. She said she expected Residents #14 and #15 to have a specific diagnosis for his Seroquel medication order. She said she did not think there was any risk to the resident from not having a specific diagnosis for the Seroquel medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's Psychotropic Drug Use policy revised 01/2021 indicated .psychotropic drug therapy shall be used only when it is necessary to treat a specific condition .the attending physician must include a reason or symptoms with any order psychotropic drug therapy .nursing documentation must include a description of target symptom(s), their frequency and expected outcomes so that the attending physician can determine if the medication are working effectively .unless the resident's medical record clearly indicates that the resident has one or more of the following specific conditions, psychotropic drugs should not be used .schizophrenia, schizo-affective disorder, delusional disorder, psychotic mood disorder .

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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** 46929 Based on observations, interviews, and record review, the facility failed to ensure in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments for 1 of 13 residents (Resident #232) reviewed for storage of medication. The facility failed to ensure that Resident #232's Blue-emu cream (a topical cream used for muscle soreness and pain) and Thera Tears eye drops (artificial tears eye drops to treat dry eyes) were not left at her bedside. This failure could place residents at risk of not receiving medications as ordered or receiving too much medication. Findings included: Record review of Resident #232's face sheet, dated 11/06/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included osteoarthritis (a degenerative joint disease that can affect the many tissues of the joint) and muscle weakness (loss of muscle strength). Record review of Resident #232's admission MDS assessment, dated 10/31/24, indicated she had a BIMS score of 12, which indicated moderate cognitive impairment. She was able to make herself understood and she was able to understand others. During an observation and interview on 11/04/24 at 09:24 AM, revealed Resident #232 was sitting in a chair in her room. There were 2 medications at her bedside including one container of Blue-Emu cream and 1 container of Thera tears. She said she used the cream and eye drops herself without help from the nurses. She said she took the cream two times a day. Record review of Resident #232's physician's orders, dated 11/06/24, indicated she did not have a physician's order for neither the Blue-emu cream nor the Thera Tears eye drops. During an observation on 11/04/24 at 11:04 AM, Resident #232's medications were still on the bedside table. Resident #232 was not in the room at this time. During an observation on 11/04/24 at 02:53 PM, Resident #232's medications were still on the bedside table. During an observation on 11/05/24 at 07:50AM, Resident #232 was sitting in her room in a chair. The cream and eye drops were on her bedside table. During an observation on 11/06/24 at 07:15AM, Resident #232 was lying in bed in her room. The cream and eye drops were on her bedside table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 10:05 AM, RN E said she was taking care of Resident #232 on 11/06/24. She said that the medications should not have been at the bedside. She said some residents could have medications at the bedside but there should be an order. She said it was possible someone could get sick from taking the medication. During an interview on 11/06/24 at 01:14 PM, the ADON said if a resident had medications at the bedside the resident should have a self-medication administration assessment. She said Resident #232 did not have one of these assessments. She said there was potential for infection, and it was possible that a demented resident could try to eat the medication. During an interview on 11/06/24 at 01:28 PM, the DON said a resident could keep medications at the bed side if there was an order and the resident had been assessed for self-administration of medication. She said otherwise, residents were not allowed to have medications at the bedside. She said Resident #232 did not have a self-administration assessment to her knowledge. She said the risk was that the resident could apply the medication wrongly or another resident could wander into the room and eat the medication. During an interview on 11/06/24 at 01:43 PM, the Administrator said her expectation was for a self-administration evaluation should be completed if the resident wants to self-administer medications. she said otherwise, the medications should be stored by the facility. She said there was not a risk to the resident having those specific medications at the bedside. She said she does not think the other wandering residents could reach to the bedside table and grab the meds at Resident #232's bedside. Record review of the facility's policy, Medication Storage, dated 04/01/11, stated: .The facility shall store all medications and biologicals in a safe, secure, and orderly manner .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review the facility failed to provide or obtain laboratory services to meet the needs of 2 of 12 residents reviewed for laboratory services. (Resident #7 and Resident #28) The facility failed to obtain a prealbumin (test protein store for wound healing) and HgbA1c (test average blood glucose levels over past 3 months) for Resident #7 as ordered by the wound care MD on 10/03/2024. The facility failed to obtain a CBC (comprehensive blood test), BMP (metabolic profile blood test), HgbA1c (test average blood glucose levels over past 3 months), and TSH (thyroid hormone blood test) for Resident #28 ordered on 07/30/2024 to be drawn on the 1st of each month. These failures could place residents at risk of not having their medications at a therapeutic level, delays in treatment, and/or deterioration in condition. Findings include: 1.Record review of an undated face sheet revealed Resident #7 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of CHF (impairment of the heart to pump blood sufficiently), Diabetes Mellitus Type II (prolonged high levels of glucose in the blood), and dementia (a group of symptoms affecting the memory). Record review of an admission MDS assessment dated [DATE] revealed Resident #7 had a BIMS of 00 which indicated a severe cognitive impairment. Record review of Resident #7's care plan dated 08/24/2024 titled Diabetes had an intervention to monitor labs as ordered. Record review of Resident #7's wound care progress note dated 10/03/2024 revealed an MD order to draw a prealbumin and HgbA1c. Record review of Resident #7's EHR on 11/05/2024 revealed no prealbumin or HgbA1c for Resident #7. 2. Record review of an undated face sheet revealed Resident #28 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of anemia (low iron in the blood), Diabetes Mellitus Type II (prolonged high levels of glucose in the blood), and dementia (a group of symptoms affecting the memory). Record review of an admission MDS assessment dated [DATE] revealed Resident #28 had a BIMS of 00 which indicated a severe cognitive impairment. Record review of Resident #28's consolidated MD orders dated November 2024 revealed Resident #28 had an order for a CBC, BMP, HgbA1c, and TSH monthly on the 1st beginning 09/01/2024. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 11/05/2024 of Resident #28's EHR revealed no labs for September, October, and November 2024. Record review on 11/06/2024, revealed Resident #28 had a CBC, BMP, TSH, and HgbA1c results in her EHR that were all normal. During an interview on 11/06/2024 9:30 a.m., RN F stated it was her job as the wound care nurse to review the wound care MD's notes and write orders for all new treatments, supplements, and labs. She stated it must have been an oversite on her part that Resident #7's prealbumin and HgbA1c were missed. She stated missing the labs could have resulted in a delay in healing for Resident #7, but it had not. She stated the wound was healed on 10/21/2024. She stated it was her job as the admitting nurse for Resident #28 to have made the lab requisitions for the monthly CBC, BMP, TSH, and HgbA1c. She stated she put the order in but became distracted by her other duties and failed to create the lab requisitions for the labs. She stated she was responsible for auditing the labs monthly to ensure they all were drawn as ordered. She stated she was unsure how she missed Resident #28's labs for 3 months. She stated not having the labs drawn could have resulted in an untreated medical condition. She stated the labs were drawn on 11/06/2024 and were all within normal limits. During an interview on 11/06/2024 at 10:04 a.m., the ADON said he expected labs to be obtained as ordered by the physician. The ADON said by not obtaining Resident #28's TSH as ordered could place the resident at risk for medication not being in therapeutic range causing things like weight changes, temperature tolerance changes, and sleepiness or trouble staying awake. During an interview on 11/06/2024 at 10:47 a.m., the DON said she expected labs to be obtained as ordered by the physician. The DON said all of the missing labs were due to the treatment nurse failing to put lab requisitions in the lab book to alert the lab to drawn them and failing to keep up with the double check system. She stated the treatment nurses was supposed to check for lab results to all ordered labs at least once weekly and failed to do so. She stated the facility was and the residents were fortunate that when the labs were drawn after noting the missing labs that the results were normal for both Resident #7 and Resident #28. Record review of the facility's undated policy titled, Lab and Diagnostic Test Results- Clinical protocol, indicated . the staff will process test requisitions and arrange for tests a nurse will try to determine whether the test was done .c. to monitor a drug level .d. report results to ordering MD

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements. 1. The facility failed to ensure foods stored in the kitchen walk-in refrigerator were thrown away when expired. 2. The facility failed to ensure a zippered bag of a white creamy substance was labeled and dated. 3. The facility failed to ensure a scoop was not left in the flour container. These failures could place residents at risk of foodborne illness and food contamination. Findings included: During the initial tour observation on [DATE] at 08:45AM included: 1) 1 Pan of pasta with a discard date of [DATE] in the walk-in refrigerator. 2) 1 Bowl of cornbread mix - discard date of [DATE] in the walk-in refrigerator. 3) 1 Pan of cake - discard date of [DATE] in the walk-in refrigerator. 4) 1 cheese, soft - discard date of [DATE] in the walk-in refrigerator. 5) 1 cheese, hard - discard date of [DATE] in the walk-in refrigerator. 6) 1 unlabeled bag of a white creamy substance in the walk-in refrigerator. 7) 1 scoop found in the flour container. During an interview on [DATE] at 08:50AM, the Dietary Manager said the white, creamy bag was whipped cream, and it should have had a label with the name of the food and an expiration date. During an interview on [DATE] at 08:23 AM, the Dietary Manager said the procedure was that each shift someone should check the walk-in refrigerator for expired foods. He said it was clear that it had not been checked over the weekend. He said he expected the expired foods to be thrown away. He said he expected the bag of whipped cream to be labeled. He said he expected there not to have been a scoop in the flour container. He said the risk to the residents was foodborne illness and cross-contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 01:43 PM, the Administrator said she expected the kitchen to have all items in the kitchen to be labeled, with an expiration and open date. She said she expected there to not have been a scoop left in the flour container. She said if food was expired then it should have been thrown out. She said the risk to the residents was foodborne illness. Record review of the facility's policy, Food and Supply Storage, last revised [DATE], stated: .All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption . .Most, but not all, products contain an expiration date. The words sell-by, best-by, enjoy-by, or use-by should precede the date. The sell-by date is the last date that food can be sold or consumed; do not sell products in retail areas or place on patient trays/resident plates past the date on the product. Foods past the use by, sell-by, best-by, or enjoy-by date should be discarded. Cover, label and date unused portions and open packages .Products are good through the close of business on the date noted on the label . .Scoops may be stored in bins on a scoop holder. The food level must be no closer than one inch below the handle of the scoop .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on observation, interview, and record review, 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 of 13 residents (Resident #18) and 1 of 1 laundry room reviewed for infection control practices. 1. The facility failed to ensure there was signage on the door of Resident #18 indicating he was on contact isolation. 2. CNA G and CNA H failed to wear appropriate PPE while providing care to Resident #18. 3. The facility failed to ensure the laundry linen carts were in a clean and repaired condition. 4. The facility failed to ensure clean linen was not stored in the laundry dirty area uncovered. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1. Record review of a face sheet dated 11/04/2024 revealed Resident #18 was a [AGE] year-old male and was readmitted on [DATE] with diagnoses including urinary tract infection, carrier of carpenium-resistant enterobacterales (a group of bacteria that are resistant to antibiotics and can cause serious infections), and pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus, making it difficult to breathe). Record review of a physician's order summary report for Resident #18 dated 11/04/24 indicated an order for Resident #18 to be placed on contact isolation related to CRE (carpenium-resistant enterobacterales) with a start date of 10/24/24. Record review of an annual MDS dated [DATE] revealed Resident #18 was understood and understood others. The MDS revealed a BIMS score of 12, indicating moderate cognitive impairment. The MDS indicated Resident #18 required partial to moderate assistance with ADL's. Record review of a care plan last revised on 10/28/24 revealed Resident #18 required isolation precautions related to CRE. There were interventions to follow facility isolation policy and to post isolation precaution on the door to the room. During an observation on 11/04/24 at 9:47 a.m., revealed there was not a sign on the door of Resident #18's room indicating he was on contact isolation. CNA H was assisting Resident #18 in the restroom with gloves and a mask on. CNA H did not have on a gown. CNA H assisted Resident #18 from the restroom to the bed in his wheelchair. CNA H then pivot transferred Resident #18 to the bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/04/24 at 9:55 a.m., CNA H she said she just answered the call light for Resident #18. She said there were no signs on the door, and she thought his isolation was over with and that was why she only wore gloves and a mask. She said Friday, 11/01/24, there were signs on the door. She said she helped him off the toilet and then back to bed. She said if the signs were still on the door, she would have worn a gown. During an observation and interview 11/05/24 at 7:50 a.m., revealed Resident #18 being assisted in his room by CNA G. Resident #18 was dressed and in his wheelchair. The CNA G did not have gloves, a gown, or a mask on. CNA G assisted Resident #18 with removing the resident's left arm from his sleeve after placing gloves on. The aide did not wear a gown at any time. There was a sign on the door indicating Resident #18 was on contact isolation. RN E said the Resident #18 was on contact isolation and there was a sign on the door. She said staff were supposed to wear gloves and gowns while providing care. She said some staff chose to wear a mask. During an interview on 11/05/24 at 9:03 a.m., CNA G she said she was aware of Resident #18 being on contact isolation. She said she never saw anyone putting on PPE in his room and did not realize how serious it was. She said she did see the sign on the door. She said she did not have a gown or gloves on. She said she did have gloves on previously when she shaved him. She said had not worn a gown at any time while providing care to Resident #18. During an interview on 11/05/24 11:08 a.m., the DON said she was one of the infection prevention nurses. She said the other one was the ADON. She said she expected appropriate signage to be on the door of isolation room. She said the sign was gone from Resident #18's door and did not know why. She said staff should have worn a gown and gloves when providing direct care. She said there should be bio-hazard boxes for doffing PPE before leaving the room. She said the signage should be a clue to staff. She said the charge nurse should be ensuring the CNAs were aware of residents on isolation. At the end of their shift, the CNAs should have made rounds to pass along the information. She said staff not wearing PPE appropriately could lead to the spread of infection. During an interview on 11/06/24 at 10:09 a.m., the ADON said staff entering a room with contact isolation should wear a mask, gloves, and a gown. She said there should be a sign on the door. She said she was the one that took the contact isolation sign down from Resident #18's door. She said Resident #18 had also been on airborne isolation. She said his airborne isolation ended and she accidently took down both signs . She said she took them down on the morning of 11/04/24. She said not having proper signage and staff not wearing proper PPE could cause an infection to be carried to other residents. During an interview on 11/06/24 at 1:27 p.m., the Administrator said there was a miscommunication concerning if Resident #18 was still on isolation. She said she would have expected a sign to have been on the door indicating Resident #18 was on contact isolation. She said she would have expected for staff to have worn appropriate PPE while providing care in the room. She said staff not wearing appropriate PPE and signage for a resident on contact isolation not being on the door could lead to the transfer of something on staffs' clothes or hands. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an Isolation - Categories of Transmission-Based Precautions facility policy dated September 2022 indicated, .Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents .When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door . so that personnel and visitors are aware of the need for and the type of precaution .The signage informs the staff of the type of CDC precaution(s), instruction for use of PPE, and/or instructions to see a nurse before entering .Contact precautions are implemented for residents with known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surface or resident-care items in the resident's environment .Staff and visitors wear gloves (clean, non-sterile) when entering the room .Staff and visitors wear a disposable gown upon entering the room if you anticipate that your clothing may become contaminated and remove before leaving the room . Record review of CDC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last updated September 2024, page 73 indicated, .Contact precautions. Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment . Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission . Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens . 2. During an observation on 11/06/24 at 8:47AM, this surveyor observed a linen cart outside the laundry room door in the hallway. The cart was falling apart on the top around the edges. There was a foam pool noodle attached to the top of the cart with duct tape. Some of the duct tape was peeling off and parts of the foam were raising off the cart. There was debris in the bottom of the cart, including food and a pepper packet and dirt. Inside the laundry room on the clean side there were two rolling carts that were also falling apart on the top around the edges. There was a leaf and a pine needle in one of the clean carts. There was a white container full of sheets on the dirty side of the laundry room that was not covered. During an interview on 11/06/24 at 09:00AM, Laundry aide A said she was aware the carts were in disrepair, and she had not thought to tell her supervisor. She said it was not possible to thoroughly clean the carts in the state they were in. She said the white container with sheets in it should not have been on the dirty side of the room and should have been covered. She said thesheets were brought in on the dirty cart, washed, and then placed in the can with no lid. She said they should have been folded and put away on the clean side of the laundry. During an interview on 11/06/24 at 09:03AM, Housekeeping Supervisor B said she needed to order new carts. She said she was unaware that the carts were in disrepair. She said she was going to put in a request for new laundry carts. She said her expectation was for the laundry aide to wash the dirty linens, then fold, and then put them away on the clean side of the laundry room. she said the risk to the residents was a possible infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Cornerstone Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 Moores LN Texarkana, TX 75503	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/06/24 at 01:43 PM, the Administrator said if the carts were falling apart then it should have been reported to maintenance for repair. She said if maintenance could not repair then the carts needed to be replaced. She said clean linens should be stored in a clean area and covered. She said the risk to the residents was possible infection for the linen carts. Record review of the facility's policy, Laundry and Bedding, last revised October 2018, stated: .3. Linen carts are cleaned and disinfected whenever visible soiled and according to the established schedule . .5. Clean lines are protected from dust and soiling during transport and storage to ensure cleanliness. 6. Clean linens are stored separately, away from soiled linens, at all times . 44128