STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676361	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Rehabilitation and Healthcare Center	535 S Austin Road Eagle Lake, TX 77434

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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 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** 35822 Based on observation, interview and record review, the facility failed to care for resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 8 residents (Resident 63), reviewed for resident rights, in that: -LVN U was standing while feeding Resident #63 her lunch in the Dining Room. This failure placed residents at risk for feeling disrespected and diminished quality of life. Record review of Resident #63's face sheet dated 06/13/24 revealed a [AGE] year-old female admitted to the NF on 11/01/2023 and readmitted on [DATE]. Resident #63's diagnoses included the following; heart failure, type 2 diabetes mellitus (when the body has difficulty controlling the blood sugar and using it for energy), hemiplegia (partial or complete paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (blood flow in the brain is disrupted) , hypertension (high blood pressure), dysphagia (difficulty swallowing), and cognitive communication deficit (difficulty in communicating). Record review of Resident #63's MDS dated [DATE] revealed a BIMS score of 3 indicating the resident's cognition was severely impaired. Further review of resident functional abilities section GG revealed that resident required supervision or touching assistance with eating. Record review of Resident #63's Physician's Orders for the month of June 2024 reflected the following order: -Dated 11/01/2023 Diet Regular texture, thin consistency. Record review of Resident #63's Comprehensive Care Plan dated 11/24/2023 and revised 02/23/2024 reflected in part: Resident has an ADL self-care performance deficit r/t dementia, stroke and requires staff assistance to complete all task. The interventions included eating set-up/ cueing and supervision-limited assist of 1 staff. Observation on 06/12/24 at 12:08PM in the Dining Room revealed LVN U was standing over Resident #63 on her right side while feeding the resident her lunch. Resident #63's lunch consisted of corn bread, black eye peas, green beans, breaded crispy pork steak, lemon pie for dessert, and beverage was water and tea. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/13/24 at 9:50AM LVN U said when feeding a resident, he was supposed to sit at eye level to create a cordial interaction with the resident. He said that was the respectful thing to do. Interview on 06/13/24 at 11:02AM the DON said staff should not be standing when feeding a resident because it did not provide the resident with dignity. Record review of the NF policy on Resident Rights revised December 2016 reflected in part: .Employees shall treat all residents with kindness, respect, and dignity . Record review of the NF policy on Assistance with Meals revised 05/21/2024 revealed in part: .Residents who cannot feed themselves will be fed with attention to safety to safety, comfort and dignity, for example: -not standing over residents while assisting them with meals.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADL's) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 3 of 11 residents (Resident #170, Resident #6, and Resident #223) reviewed for ADLs. 1. The facility did not provide Resident #170 with showers after the resident reported asking for a shower on his scheduled shower day of 06/11/2024. 2. The facility failed to ensure Resident #6 was provided grooming (toenails care). 3. The facility failed to ensure Resident #223 was provided grooming (shower). These failures could place residents who were dependent on staff for showering at risk of not receiving care and services to meet their needs. Findings included: 1.1Record review of Resident #170's face sheet dated 06/12//2024 revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included: gangrene (a dangerous and potentially fatal condition that happens when the blood flow to a large area of tissue is cut of), atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), type 2 diabetes mellitus (high blood sugar) with foot ulcer, gout (arthritis that causes severe pain, swelling, redness and tenderness in joint), hyperlipidemia (condition in which there are high levels of fat particles (lipids) in the blood), edema (swelling caused by too much fluid trapped in the body's tissues), and diabetes mellitus with diabetic neuropathy (nerve damage that occurs with diabetics). Record review of Resident #170's Resident Assessment and Care Screening MDS, dated [DATE], revealed Focus: The resident admitted for short term care. Record review of Resident #170's Baseline Care Plan, dated 06/09/2024, revealed the resident had a surgical wound where gangrenous tissue was removed from the left foot 5th digit and surrounding area. Goal: The residents surgical wound will heal without complications by the review date Initiated: 06/10/2024. Intervention: Monitor for swelling, redness, drainage, odor, increased pain, document wound progress weekly, treatment as ordered, wound vac as ordered. During an observation and interview on 06/11/2024 at 09:34 a.m., revealed, Resident #170 was in his room, sitting on side of bed with family at the bedside. Both legs still from his toes to his mid-thigh appeared dry and flaky. He stated that he admitted on [DATE] in the early morning hours and had not had a bath or a shower since admitting. He stated he requested some wipes or a wet towel from CNA A to give himself a bath on a.m. of both 06/10/2024 and 6/11/2024, but he had not yet received the items. He stated that he had a wound vac on his left foot and was not sure if he could take a shower, but he definitely wanted to wipe down. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/11/2024 at 03:35 p.m., revealed Resident #170 was in his room lying back on his bed. Both legs still from his toes to his mid-thigh appeared dry and flaky. He stated he had not yet received towels to wipe down nor had a staff offered him a bed bath or shower. During an observation and interview on 06/12/2024 at 01:36 p.m. Resident #170 was lying back on his bed with left foot wrapped in gauze. Both legs still from his toes to his mid-thigh appeared dry and flaky. He stated that he told CNA A that he would like a shower. He stated that CNA A told him that it was not his shower day, but that she would find out when his shower day would be, and he would be given a shower/bed bath on that day. He stated again, he had not gotten a bath since admitting 06/09/2024. He stated that his foot was now wrapped in gauze so he was unsure would he receive a shower but would like to receive some wipes so he could do a wipe down of his under arms and private area at least, because he wanted to be clean, and he could use some lotion. During an interview on 06/12/2024 at 02:51 p.m. the DON stated she was not aware that Resident #1 had requested a shower. She stated that she would go speak to the resident and ensure he received a shower. During an interview on 06/12/2024 at 03:02 p.m., the DON stated that she spoke with the CNA B on his hall who would give the Resident #1 a bath. During an observation/interview on 06/13/2024 at 9:58 am., LVN A stated that she was the charge nurse on Resident #1's hall. She stated she had no reports of a resident who declined or requested a shower. She stated she was unaware that Resident #170 requested a wipe down. She stated based off the shower schedule, Resident #170 should have been provided a shower/bed bath on Tuesday, Thursday and Saturday which would have been 6/11/2024 and 6/13/2024 on the 2 pm - 10 pm shift. She looked through the shower book for shower sheets and there were no shower sheets available for Resident #170. She stated that if there were shower sheets, they would have been completed by the resident's CNA and then provided to the ADON for review. During an interview on 06/13/2024 at 10:23 am. CNA A stated she had worked for the facility for nearly 6-months. She stated she worked on Resident #170's hall 06/11/2024 from 2pm to 10 pm. She stated Resident #170 asked for a wipe down or shower on 06/11/2024. She stated that she told the resident it was not his shower day, but she would try and squeeze him in, but was unable to get to the resident. She stated she did not inform LVN A that the resident needed a bath. She stated that she does not recall by who but was told that Resident #170 received a shower and shave on 06/12/2024 on the 2pm to10 pm shift. She stated that she was to complete shower sheets on residents after completing resident showers. She stated that she did not complete any shower sheets on the residents she provided showers to between 06/11/2024 - 6/13/2024. She stated it was important that residents receive showers and completing the shower sheets to show that the showers were performed, and residents were clean. She stated that she did document in the resident's electronic chart. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/24 at 01:27 p.m., the Administrator stated that she was not aware that Resident #170 had requested a towelettes to wipe down on 06/11/2024 or 06/12/2024. She stated that residents were assigned shower days 3-times a week, but if a resident asked for one in between, staff were to provide a shower. She stated if a resident requested wipes or a towel to wipe down, staff were to provide the resident with soap, water, and a towel. She stated that generally new admits were assessed by the admission nurse and usually the following day by physical therapy and thereafter, the resident would be offered a shower or receive a shower on their next assigned shower day. She stated that CNA B worked on Resident #170's hall and was responsible for providing the resident with a bed bath or shower. She stated that if Resident #170 did not receive a shower that it was a mistake. She stated that she expected her staff to follow resident shower schedules. During an interview on 06/13/2024 at 1:59 p.m. CNA B stated that she had worked for the facility for 1 year. She stated that on 06/11/2024, she was Resident #170's CNA. She stated that she offered the resident a shower, but he told her, Not right now he was waiting on his wound vac to be connected. She stated that she left and did not check back to see if the resident needed a shower before her shift ended at 2:00 p.m. She stated that she did not informed LVN A and did not make notation that the resident would wait on his shower until later. She stated she should have gone back around and remind the resident that he could have a shower and report to LVN A if he declined. She stated the shower policy and procedure made note that the staff were to document showers. 2.Record review of Resident #6's face sheet dated 06/13/24 revealed a [AGE] year-old male was initially admitted on [DATE] and readmitted on [DATE]. Resident #6 had diagnoses which included: cerebral infarction (damage to the tissues in the brain due to a loss of oxygen to the area), dementia (impaired ability to remember think or make decision that interferes with doing everyday activities), peripheral vascular disease(the reduce of blood flow to a body part other than the brain) and heart failure (heart does not pump enough blood for the body's needs). Record review of Resident #6's quarterly MDS assessment dated [DATE] reflected in part . [Resident #6's] BIMS of 09 which indicated moderately impaired cognition. [Resident #6] functional status revealed resident dependent on staff with all ADL's . Record review of Resident #6's care plan-initiated date 03/03/24 reflected in part .(Resident #6) had ADL self-care performance deficit related to dementia, hemiplegia, and stroke. Interventions: skin inspection: the resident requires skin inspection during routine care observation . During an observation on 06/11/26/24 at 11:25 a.m., revealed Resident #6's toenails were long; the right big toenail was calcified and long, and the toenail pointed upward. Both second toenails were long. During an interview on 06/13/24 at 11:05 a.m., the Administrator said the nurse would tell the social worker the name of the resident who needed to see the podiatrist and the resident's name on the podiatrist list. The administrator said the podiatrist would send the list of residents they had before she came to the facility. Then, the social worker would add any resident who needed to see the podiatrist to the list sent by the podiatrist. The administrator said if the nurses could not cut the resident's toenails, the social worker would put the resident's name on the podiatrist list. The administrator said if the toenails were causing the resident pain, they would ask the podiatrist to see the resident or take the resident to another doctor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/24 at 11:12 a.m., the ADON said the podiatrist came to the facility on ce every three months. The ADON said the podiatrist has the names of all the residents, with the expectation of the residents who went to their doctor. The ADON said the podiatrist cut the diabetic residents' toenails, and if the resident did not have diabetes, the nurses would cut the resident's toenails. The ADON said if the resident's toenails were thick and calcified, the podiatrist would cut them. The ADON said if the resident's toenails got caught on socks, it could cause pain to the resident. During an observation and interview on 06/13/24 at 11:18 a.m., the ADON said she could see Resident #6's toenails were long, and the toenail on the right big toe was long and pointed upward. The ADON said she was not aware Resident #6 needed to see a podiatrist. The ADON said she and the DON monitored the nurses doing rounding. During an interview on 06/13/24 at 12:41 p.m., the DON said the podiatrist came once every three months. The DON said that when it was time for the podiatrist to come, they would send a list of the residents they would see, and the facility would send a list of new residents that were not on the list. The DON said the nurses cut the residents' toenails if they do not have diabetes, and the podiatrist would cut the toenails of the diabetic residents. The DON said if a resident needed to have their toenails cut by the podiatrist, the facility would made arrangements for the resident's toenails to be cut. During an interview on 06/13/24 at 1:13 p.m., the DON said she went and assessed Resident #6's toenails. The right big toenail was very long, and the other toenails were long but not as long as the right big toenail. The DON said the nurse monitored the aides when they made rounds. The DON said she was unaware that Resident #6's toenails were long and that the treatment nurse did skin assessments on all residents, including Resident #6. During a telephone interview on 06/13/24 at 1:53 p.m., the Social Worker said the podiatrist comes about every two months, and they were in the facility at the beginning of June 2024. The social worker said she became aware if a resident needed to see a podiatrist when the nurse told her. The social worker said nobody had told her Resident #6 wanted to see the podiatrist. The social worker checked the last zipped file the podiatrist sent and said the previous time the podiatrist came to the facility was 05/09/24, and Resident #6's name was not on the list. During an interview on 06/13/24 at 2:09 p.m., LVN U said the treatment nurse did the skin assessment for all the residents, including Resident #6, and when the wound care nurse was not available, the floor nurse does the skin assessment and gives the skin assessment to the wound care nurse. LVN U said nobody told him Resident #6's toenails were long. LVN U said the aide had to report to the nurse that Resident #6's toenails were long, and the nurse would send the names of the residents to the DON or ADON, and they would give the name to the activity director who sent the residents name to the podiatrist. LVN U said if Resident #6's toenails were not cut, the circulation would be poor, and the toenails could get caught on the bed linen, which could cause injury to Resident #6. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/24 at 2:37 p.m., CNA A said she gave Resident #6 a bed bath yesterday (06/12/24), and his toenails were long, but she did not tell the nurse because she forgot. CNA A said the podiatrist came once a month. CNA A said the aides told the nurse about the resident's toenails, and the nurse told the office staff. CNA A said if Resident #6 toenails were long, it could cause Resident #6's toenails to grow inward and may hurt or cut Resident #6's skin. CNA A said the charge nurse monitored the aides when the nurses made rounds. During an interview on 06/13/24 at 4:45 p.m., the Treatment Nurse said she does the skin assessment for all the residents. The Treatment Nurse said she told the Social Worker that Resident #6 toenails were long, and the social worker said she would put Resident #6 on the list. The treatment nurse said she was just told today (06/13/24) that the podiatrist does not see skilled residents, and Resident #6 was a skilled resident. The Treatment Nurse said Resident #6's long toenails could have ingrown toenails, or the toenails could have gotten snagged and hurt the resident. 3.Record review of Resident #223's face sheet dated 06/13/24 revealed an [AGE] year-old female was admitted on [DATE]. Resident #223 had diagnoses which included: chronic obstructive pulmonary disease (lung disease causing restricted airflow and breading problems), hypertension (when the pressure in the blood vessels is too high), and heart failure (heart does not pump enough blood for the body's needs). Record review of Resident #223's MDS assessment revealed the resident MDS was not due until 06/13/24. Record review of Resident #223's baseline care plan dated 06/08/24 reflected in part . (Resident #223) required moderate to extensive assistance with shower/bath . During observation and interview on 06/11/24 at 11:56 a.m., Resident #223 said she asked staff to shower on Saturday when she was admitted to the facility (06/08/24), and she was told by the staff that the residents were not showered on weekends. Resident #223 said she wanted to be showered and has yet to be showered as of today. During medication administration observation on 06/12/24 at 9:10 a.m., Resident #223 said the staff still had not showered her. Resident #223 said she felt dirty, and her hair was tangled and dirty. During an interview on 06/13/24 at 8:37 a.m., the ADON said residents are showered at least three times a week, and if a resident requested a shower over the weekend, the staff are supposed to shower the resident. The ADON said she was unaware Resident #223 wanted to be showered and was not. The ADON said the aides would had filled out shower sheets and the shower sheets were given to the DON. The ADON said if Resident #223 needed to be showered and she was not showered, then Resident #223 would feel dirty and unclean. During an interview on 06/13/24 at 9:00 a.m., the DON said residents could get showers on weekends, and she was not aware that Resident #223 did not get a shower over the weekend or on Monday (06/10/24). The DON said she was given a shower on Wednesday(06/12/24) evening. The DON said she did not have any shower sheets for Resident #223 before yesterday (Wednesday). The DON said if Resident #223 wanted a shower and it was not given, it was a dignity issue. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/24 at 9:44 a.m., LVN U said Resident #223 told her yesterday(06/12/24) around 8:00 a.m., and he told Resident #223 he would check when her shower day was and LVN U said he told one of the aides and he thought the aide was from the evening shift. LVN U said Resident #223 shower days were on Monday, Wednesday and Friday on the 2 to 10 p.m. shift. LVN U said he told the aide who was working the morning shift, and she said she was busy. LVN U said Resident #223 would not feel happy and may have body odor for days. During a telephone interview on 06/13/24 at 1:34 p.m., CNA M said she did not work with Resident #223 over the weekend and worked with Resident #223 yesterday(06/12/24). CNA M said when Resident #223 told her she needed a shower, she showered Resident #223, which was her shower day. Resident #223 loved it, and Resident # 233 said thank you after the shower. CNA M said if Resident #223 needed a shower over the weekend, the staff should have showered her because it was her right. CNA M said if Resident #223 needed a shower and she did not get showered, Resident #223 would be upset. Record review of the facility policy on bath, shower and tub dated 2001 MED - PASS, Inc. (Revised February 2018) reflected in part . the purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin . Record review of the facility policy on fingernails, toenails care dated 2001 MED PASS, Inc. (Revised February 2018) reflected in part . the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . Record review of policy Activities of Daily Living (ADL), Supporting reflected: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. A sample of shower logs were requested on 06/12/2024 at 02:38 p.m. for Resident #70, while at the facility. The facility did not provide documentation of refusals for showers, showers or shower assistance given for the last 30-days prior to exit. 44669

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one of three residents (Resident #7) reviewed for quality of care. The facility failed to ensure Resident #7 was assessed by LVN A for injuries after her fall on 06/11/2024. This failure placed residents at risk for potential injuries, pain, and hospitalization . The findings were: Record review of Resident #7's face sheet dated 06/12/2024 revealed a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included: hypertension, schizophrenia, psychosis not due to a substance. or known physiological condition, insomnia, other seizures, age-related osteoporosis without current pathological fracture (break in the bone not caused by force or impact), hypothyroidism (body lacking thyroid hormone), hyperlipidemia (high levels of fat in the blood), drug induced subacute dyskinesia (repetitive, involuntary movements), muscle weakness, other abnormalities of gait and mobility, dementia, with agitation, other lack of coordination. Record review of Resident #7's quarterly MDS, dated [DATE], revealed she was admitted to the facility on [DATE] with diagnoses of drug induced subacute dyskinesia, hypothyroidism, other lack of coordination, age-related osteoporosis w/out current pathological fracture, muscle weakness, generalized, other abnormalities of gait and mobility, insomnia, seizure disorder, psychotic disorder, and schizophrenia. Further review revealed Resident #7's BIMS was 7 out of 15 which suggested severe cognitive impairment. Review of Resident #7's Care Plan revised 03/22/2023 revealed: Focus: Resident had impaired cognitive function/dementia or impaired thought processes r/t Dementia, Schizophrenia aeb- memory deficits, wanders, impaired decision making. Date Initiated: 09/16/2021. Goal: Resident will remain current level of cognitive function through the review date. Date Initiated: 09/16/2021. Intervention: Ask yes/no questions in order to determine the resident's needs. Date Initiated: 09/16/2021. COMMUNICATION: Use the resident preferred name (Resident #7). Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues stop and return if agitated. Date Initiated: 09/16/2021, Revision on: 12/21/2021. Cue, reorient and supervise as needed. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 09/16/2021. Engage the resident in simple, structured activities that avoid overly demanding tasks. The resident prefers (coloring, dancing, visiting, reading) Date Initiated: 09/16/2021. Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Date Initiated: 09/16/2021. Observation on 06/11/2024 at 10:08 a.m., revealed Resident #7 and CNA C throwing a bouncy ball into a tabletop basketball hoop. CNA C threw the ball towards the hoop and the ball bounced off a crossed the room. Resident #7 immediately ran after the ball, upon reaching the ball the resident attempted to stop when her feet pivoted underneath her until she stopped losing her balance, fell to her buttocks, immediately bounced back up, picked up the ball, ran back towards the basketball hoop, and threw it at the hoop. CNA C asked resident was she ok three times, but the resident did not respond. A few minutes later Resident #7 was observed sitting in a chair with no expression. CNA C asked resident was she tired, and resident did not respond. Interview on 06/12/2024 at 03:02 p.m., the DON stated that she was not aware that Resident #7 had a fall in memory care on 06/11/2024 at 10:08 a.m. She stated the fall should have been documented to outline what assessments and follow-up from the fall were performed. She stated she would immediately assess the resident to ensure the resident had no injuries. Interview on 06/12/24 at 03:17 p.m., the DON stated that she had LVN A assess Resident #7. She stated that Resident #7 was eating chips and drinking soda when she entered the memory care unit. She stated that all of the resident's vitals were in the normal range and there were no visual indications of any injuries and the resident denied pain. She stated that LVN A would document her assessment and it would be available in the resident's electronic chart. Interview on 06/12/2024 at 03:40 p.m., CNA C stated that when Resident #7 fell she reported to the med aid who reported to LVN A. Interview on 06/13/24 at 9:58 am., LVN A stated on 06/11/2024 in the afternoon the med aid reported to her that Resident # 7 had placed her hand on a chair and bent down to pick up something, lost her balance while bending down and sat down on the floor, stood up and continued to play basketball. She stated that she was preforming another task when she received the report. She stated thereafter, she spoke with the resident and did not get an indication that the resident had a fall or any injuries. She stated had she known the resident had fallen, the resident would have had a head-to-toe assessment that would have included checking the resident's skin, assessing the resident's extremities for any bruising or bones out of place and an incident report would have been completed within 24-hrs. She stated on the afternoon of 06/12/2024 she learned from the DON that the resident incident actually consisted of the resident having a witnessed fall. At that time, she performed a head-to-toe assessment, and the assessment was completed the morning of 06/13/2024 when she came in on shift at 7:00 a.m. She stated that she had forgotten to complete the report before ending her shift on 06/12/2024. Record review of Resident #7's progress notes dated between 05/13/2024 to 06/12/2024 revealed no documentation relating to resident's fall on 06/11/2024 at 10:08 a.m. Record review on of Resident #7's Evaluations/Assessments dated between 05/08/2024 to 06/12/2024 revealed no documentation relating to resident's fall on 06/11/2024 at 10:08 a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Incident Report dated 06/13/2024 at 7:01 a.m. revealed: Resident #7. Incident Location: Resident Room. Person Preparing Report: LVN A. Incident Description: Nursing Description: This nurse was called into memory unit common area. Staff reported resident had a witnessed fall without injury. Upon entering unit, resident was noted playing basketball. Resident Description: Resident unable to state what happened. Per Staff, something fell on the floor and resident bent down to pick it up. The resident placed one hand on the chair, bent down and lost balance causing her sit on floor. The resident propped herself back up and continued to play basketball. Immediate Action Taken: Description: this nurse assessed resident for injuries, none noted. Able to move all extremities with ease. Skin assessment done and no skin tears noted. Vitals signs WNL. Resident denies pain. Resident Taken to Hospital? No. Injuries Observed at Time of Incident: No. Injuries observed at time of incident. Record review of Fall Prevention Program Policy dated 06/10/2024 reflected: All residents will be assessed for the risk for falls at the time of admission, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this assessment, specific interventions will be implemented to minimize falls, avoid repeat falls and minimize falls resulting in significant injury. If a fall occurs, the following will be done: a. The licensed nurse will complete a thorough assessment of the resident to evaluate for injury. b. The licensed nurse will notify the physician and the family/responsible party. c. Treatment will be initiated per physician orders. d. An incident report will be completed. e. The resident's plan of care will be updated to reflect interventions. f. The interdisciplinary team will be notified, a Post Fall Review completed, causative factors evaluated and appropriate referrals made (medication review, therapy, restorative, etc.). The Post Fall Review must be completed within 72 hours of a fall. g. Therapy Screen will be conducted. h. All resident falls will be monitored through the clinical standards committee. i. The DON or designee will track, and trend falls on a monthly basis. j. The DON/ designee will report results to the Quality Assurance/ Improvement Committee. k. If the resident with dementia sustains a fall, in addition to the nursing assessment, the facility will also prioritize diagnostics such as STAT Xray/transfer to ER for appropriate investigation and intervention.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #222) reviewed for incontinent care. 1. The facility failed to ensure CNA Z and CNA E followed proper Foley bag placement during Hoyer lift transfer on Resident #222. This failure could place residents at risk for pain, infection, injury, and hospitalization . Findings included: Record review of Resident #222's face sheet dated 06/13/24 revealed an [AGE] year-old male was admitted on [DATE]. Resident #222 had diagnoses which included: obstructive and reflux uropathy (urinary tract disorder that occur when urine flow is blocked, causing urine to backup and may cause injury to the kidneys), dementia (impaired ability to remember think or make decision that interferes with doing everyday activities), hypertension (high or raised blood pressure) and disorder of kidney and ureter kidney (damaged kidney and can't filter blood, blocks or slows the flow of urine). Record review of Resident #222's MDS assessment revealed the resident assessment was not due because he was a new admit. Record review of Resident #222's baseline care plan date 05/31/24 reflected in part .(Resident #222) had indwelling catheter . Record review of Resident #222's physician's order dated June 2024 reflected in part . change indwelling F/C PRN, dislodgement/patency .as needed related to obstructive and reflux uropathy start date 06/07/24 . During an observation on 6/11/24 at 11:45 a.m., revealed Resident #222 was being transferred from the wheelchair to the bed by CNA E and CNA Z. When CNA Z unhooked the Foley bag from the wheelchair the Foley bag fell on the floor, and CNA Z picked it up from the floor and placed the bag on Resident #22's lap. At the same time, CNA Z hung the Hoyer lift(medical equipment that allow a person to be lifted and transferred with a minimum of physical effort) pad strips to the Hoyer lift. When CNA Z and CNA E started to lift Resident #222 from the wheelchair, CNA E hung the Foley bag on the cradle of the Hoyer lift. When the resident was transferred to the bed, CNA E hung the Foley bag on the bed rail. During an interview on 06/11/24 at 12:09 p.m., Resident #222 said LVN U had not changed his Foley bag since he was transferred to bed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/24 at 1:15 p.m., LVN U said CNA E or CNA Z did not tell him Resident #222's Foley bag fell on the floor. LVN U said either CNA E or CNA Z should have told him that Resident #222's Foley bag had fallen on the floor and that he would have changed the bag to prevent infection such as UTI. LVN U said the nurse monitored the aides to ensure they provide care as required. LVN U said he had skills checked off on how to work with a resident who had a Foley. LVN U said either CNA E or CNA Z should have held the Foley bag below the bladder, and the aides should not have hung the Foley bag on the Hoyer lift. During an interview on 06/12/24 at 1:19 p.m., the DON said if Resident #222's Foley bag fell on the floor, CNA Z should not have placed the Foley bag on Resident #222's lap because the floor was dirty. The DON said the Foley bag should be below the bladder during transfer and not hung on the Hoyer lift. The DON said the Foley bag should be below the bladder to drain the urine properly. The DON said there would be pain or discomfort for Resident #222, and he could get a UTI. During an interview on06/11/24 at 1:33 p.m., CNA Z said the Foley beg fell on the floor, and she placed the Foley bag on Resident #222's lap, and CNA E hung the Foley bag on the Hoyer lift when Resident #222 was lifted from the chair. CNA Z said after Resident #222 was transferred to bed, the Foley was hanged on the bed. CNA Z said the nurse should change the Foley bag because the floor was dirty, and the Foley could be pulled out too when CNA E hung the Foley bag on the Hoyer lift. CNA Z said the Foley bag should be changed to prevent the resident from getting infected. CNA Z said she had skills checked off on Foley care. CNA Z said the charge nurse monitored the aides during rounding . During an interview on 06/13/24 at 9:05 a.m., the ADON said CNA Z and CNA E should keep the Foley bag below the bladder even when Resident #222 was transferred with a Hoyer lift. The ADON said when CNA E hung the Foley bag on the Hoyer's lift, the bag was above the bladder, and the urine would have flowed backward into Resident #222's bladder, which could have caused pressure and pain. The ADON also said Resident #222 could develop a UTI. The ADON said CNA Z or CNA E should have called the nurse to come and change the bag once the Foley bag fell on the floor because the floor was dirty and there was an infection control issue. The ADON said the nurse monitored the aides during rounding. During an interview on 06/13/24 at 1:31 p.m., CNA E said she was told yesterday(06/12/24), after they had transferred Resident #222, to call the nurse to change the bag if a Foley bag fell on the floor. CNA E said she was taught to hang the Foley bag on the Hoyer during the Hoyer lift transfer, but she was told not to hang the Foley bag on the Hoyer yesterday but was not told where to place the Foley bag during transfer. CNA E said the Foley bag that fell on the floor and hung above the bladder could cause infection for Resident #222. CNA E said the charge nurses monitored aides when they made rounds. CNA E said she had a skill check-off and in-service on Foley care. Record review of the facility policy on catheter care, urinary revised and reviewed January 2023, Revised March 2024 reflected in part . the purpose of this procedure is to prevent catheter-associated urinary tract infections . general guidelines . maintaining unobstructed urine flow . #3. the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .infection control . #2b. be sure the catheter tubing and drainage bag are kept off the floor .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review, the facility failed to provide care and services to prevent complications for 1 of 8 residents (Resident# 1) reviewed for enteral nutrition, in that: -CNA S lowered the head of bed on Resident #1 while the resident was receiving continuous gastrostomy feedings on 06/13/24. -CNA T entered Resident #1's room on 06/13/24 while the resident was receiving continuous gastrostomy feedings with the head of bed flat and did not elevate the head of bed instead, left the room to get the nurse. -LVN U flushed Resident #1's gastrostomy tube by pushing the water in instead of letting the water go in by gravity. The failures placed resident at risk for unwanted abdominal discomfort, aspiration (when food, drink, or foreign objects are breathed into the lungs) pneumonia, hospitalization , and decrease in quality of life. Findings: Record review of Resident #1's face sheet dated 06/13/2024 revealed an [AGE] yearl old female admitted to the NF originally on 01/22/2016 and again on 05/21/2024. The resident's diagnoses included the following: cerebral infarction (disrupted blood to the brain), heart failure, gastro-esophageal reflux disease (stomach content often flows up in the esophagus, a tube that carries food and liquids form the mouth to the stomach)without esophagitis (irritation of the esophagus), gastrostomy (surgical procedure that creates an opening into the stomach), angina pectoris (a type of chest pain cause by reduced blood flow to the heart), type 2 diabetes mellitus (when the body has difficulty controlling the blood sugar and using it for energy) without complications, Alzheimer's Disease (a disease that destroys memory and other mental functions), pneumonia (infection in the lung), and contracture (shortening of the muscle, tendons, skin, and tissues preventing normal movement) of the right left knee, left knee, left hand, and right hand. Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 3 indicating that resident cognition was severely impaired . Further review section V- Care Assessment Summary revealed that resident was triggered for having a feeding tube Record review of Resident #1's Comprehensive Care Plan dated 03/27/2021 and revised 06/02/2021 revealed the resident was being care planned for risk of aspiration, she had a stroke with increase dysphagia (difficulty swallowing), was now NPO with enteral feedings as her source of nutrition/hydration. The interventions included the following: -Every shift HOB elevated at all times 30-45 degrees. Record review of Resident #1's Physician's Orders for the month of June 2024 reflected the following: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dated 09/24/2023 Enteral feed, Glucerna 1.2 cal at 65ml/hr times 22 out of 24 hrs. form 12am-2am, water 150ml/4Hrs. -Dated 07/23/2021 Enteral (related to the intestines) Feed every shift HOB elevated at all times 30-45 degrees. -Dated 07/23/2021 Flush PEG tube with 30ml H2O before first medication, 10ml between each medication, and 30 ml after last medication every shift. Record review of Resident #1's MAR for the month of June2024 revealed that resident was receiving gastrostomy feedings as ordered by the physician. Observation on 06/13/24 at 10:10AM revealed CNA S and CNA T were preparing to provide incontinent care for Resident #1. Resident #1 was resting in bed with the HOB elevated receiving continuous gastrotomy feedings Glucerna 1.5 cal at 65ml/hr along with a water flush. CNA S entered Resident #1's room washed her hands and went over to the resident's bed side and began to lower the head of the bed while the gastrostomy feeding was infusing. Further observation was made of a sign directly over the resident's bed that reflected Please keep my head of bed elevated at 45 degrees at all times thank You!! CNA S walked out of the room and returned right back with CNA T. CNA T sanitized her hands and placed on a pair of gloves. At 10:14AM CNA T removed her gloves and said she had to go and get the nurse. At 10:15AM CNA T returned to the room and said that the nurse was coming to the room. At 10:17AM LVN U came to the room to stop the continuous gastrostomy feedings. LVN U told CNA T to raise the head of bed. CNA T raised Resident #1's head of bed. Resident #1 did not appear to be in any distress, respirations were even and unlabored. LVN U told CNA S and CNA T before they proceeded with incontinent care he needed to disconnect the resident from her feedings and flush the resident's gastrostomy tube. At 10:19AM LVN U proceeded to draw up 60 ml of water in an irrigation syringe and flushed the resident's gastrotomy tube by pushing the water through the tube instead of letting the water go in by gravity. Interview on 06/13/24 at 10:33AM CNA S said she had been working at the NF since 2015. CNA S said she had been a CNA for almost [AGE] years and had taken care of residents with continuous gastrostomy feedings. CNA S said she had been trained that when caring for a resident with a gastrotomy tube to make sure she did not pull on the tubing, to always make sure that the tube was disconnected before providing care, and making sure the head of bed was elevated when feedings were infusing to prevent the resident from choking or aspirating. CNA S said she was called to Resident #1's room to assist with incontinent care and thought the resident feeding had been stopped. CNA S said it was her fault for not checking first before lowering Resident #1's head of bed. Interview on 06/13/24 at 10:38 AM CNA T said she had been working at the NF on and off for 6 years. CNA T said she had received training on how to provide care for residents receiving continuous gastrotomy feedings. CNA T said whenever a resident was receiving continuous gastrostomy feedings, the CNA was supposed to call the nurse prior to administering care so the feedings could be stopped and not to place resident head of bed flat when the feedings were infusing to prevent the resident from aspirating. CNA T said when she entered Resident #1's room she saw the resident lying with the head of bed flat. CNA T said she should have elevated the head of bed before leaving the room to go and get the nurse. CNA T said she did not know why she responded like that but her first clue was to get the nurse. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/13/24 at 10:45AM LVN U said it was not correct for Resident #1's head of bed to be flat when receiving gastrostomy feedings because it placed resident a risk for aspirating. LVN U said the correct way to flush a G-tube is by of gravity. Interview on 06/13/24 at 11:02AM the DON said when administering medications and flushing the gastrostomy tube, then procedure should be done by way of gravity to avoid introducing air into the stomach. The DON said this placed the resident at risk for discomfort or pain. The DON said the gastrostomy feeding should be stopped before providing care and the head of bed should be elevated if the feedings are infusing. The DON said this needed to happen to prevent resident from aspirating. Record review of the NF policy on Enteral Nutrition revised January 2023 revealed in part: .Adequate nutritional support through enteral nutrition is provided to residents as ordered .The provider will consider the need for supplemental orders, including: Head of bed elevation . Staff caring for residents with feeding tubes are trained on how to recognize and report complications associated with insertion and /or use of feeding tube, such as aspiration .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care and services, including breathing treatment administration was provided such care, consistent with professional standards of practice for 1 of 8 residents (Resident #1) reviewed for respiratory therapy in that: The facility failed to change Resident #1's respiratory equipment in a timely manner. This failure could place residents at risk for respiratory infections. The findings were: Record review of Resident #1's face sheet dated 06/13/2024 revealed an [AGE] yearl old female admitted to the NF originally on 01/22/2016 and again on 05/21/2024. The resident diagnoses included the following: cerebral infarction (disrupted blood to the brain), heart failure, gastro-esophageal reflux disease (stomach content often flows up in the esophagus, a tube that carries food and liquids form the mouth to the stomach)without esophagitis (irritation of the esophagus), gastrostomy (surgical procedure that creates an opening into the stomach), angina pectoris (a type of chest pain cause by reduced blood flow to the heart), type 2 diabetes mellitus (when the body has difficulty controlling the blood sugar and using it for energy) without complications, Alzheimer's Disease (a disease that destroys memory and other mental functions), pneumonia (infection in the lung), and contracture (shortening of the muscle, tendons, skin, and tissues preventing normal movement) of the right left knee, left knee, left hand, and right hand. Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 3 indicating that resident cognition was severely impaired. Further review did not reveal that resident was receiving respiratory treatment. Record review of Resident #1's Comprehensive Care Plan dated 03/21/2024 revealed that resident was being care planned for altered respiratory status/difficulty breathing r/t CHF & hs of pneumonia. The interventions included administer albuterol as ordered . Record review of Resident #1's Physician's Orders for the month of June 2024 reflected the following: -Albuterol Sulfate inhalation nebulization solution 0.63 mg/3ml (albuterol sulfate) 1 inhalation orally via nebulizer two time a day related to heart failure. Record review of Resident #1's MAR for the month of June 2024 revealed that resident was administereding the medication albuterol sulfate as ordered by the physician. Record review of Resident #1's Comprehensive Care Plan dated 03/21/2024 revealed that resident was being care planned for altered respiratory status/difficulty breathing r/t CHF & hs of pneumonia. The interventions included administer albuterol as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/11/24 at 9:11AM revealed Resident #1 was resting in a recliner at bedside. Observation was made of a breathing machine on the left side of bed sitting on the nightstand. Connected to the machine was plastic tubing. Connected at the end of the tubing was a face mask. The mask was inside of a plastic bag. The date on the outside of the bag reflected 05/20/24. Further observation of the date on the mask reflected 05/20/24. Further observation was made of resident having a suctioning machine in the room by the breathing machine sitting on a table. There was an empty clear cannister connected to the suction machine. Connected to the cannister was tubing and at the end of the tubing was an oral yankauer (a device that is used to suction or remove fluids and debris) suction tip. The yankauer was inside of an open wrap. The date on the outside of the open wrap was dated 05/20/24. Observation on 06/13/24 at 10:40AM revealed Resident #1 was resting in bed quietly. Further observation was made in the room of respiratory equipment (oral yaunker and breathing mask) with a date that reflected 05/20/24. Observation was made of clear fluid like secretions inside of the cannister. Interview on 06/13/24 at 10:33AM the Infection Control Nurse/ADON said she had been the NF Infection Control Nurse for about a year. The ADON said respiratory equipment should be changed weekly on the Sunday night shift for infection control. The ADON said each resident had an ambassador who was a department head assigned to them. The ADON said that ambassador was supposed to check on the residents each day ensuring everything was bagged and labeled correctly. The ADON said she would have to check to see who Resident #1's ambassador was. Interview on 06/13/24 at 10:45AM LVN U said he did not know how often respiratory equipment should be changed. LVN U said he would guess maybe once or twice every two weeks. LVN U said he administered breathing treatments to Resident #1's once on his shift. LVN U said he sometimes used the oral yankauer to suction out resident mouth after a breathing treatment. Interview on 06/13/24 at 11:02AM the DON said respiratory equipment should be changed at least weekly for infection control. The DON said the NF did have a policy on the care of respiratory equipment. The DON said she would have to check to see if nonclinical staff had been in-serviced on what to look for as an ambassador when making rounds on the residents that they were assigned to. Interview on 06/13/24 at 11:25AM with the Ambassador for Resident #1 said she did rounds every morning and evening on the residents she was assigned to. The Ambassador said she checked to see if the residents' rooms were clean and if anything looked out of order in general. The Ambassador said she was not clinical. The Ambassador said she just looked to see if any equipment that the resident was using had a date on it. The Ambassador said if a resident was on oxygen, she did check to see if the humidifier bottle had fluids inside of it. The Ambassador said she was not familiar with how often respiratory equipment needed to be changed because she was not a nurse. Record review of the NF Infection Prevention and Control Program revised 01/01/2024 revealed in part: An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 11% based on 4 errors out of 34 opportunities, which involved 2 of 7 residents (Resident #223, and Resident #1) reviewed for medication errors. 1-LVN U left a substantial amount of albuterol sulfate inhalation solution 0.083% (2.5MG/3ML) in the mask chamber after the medication was administrated through a nebulizer machine to Resident #223. 2-LVN U poured away a substantial amount of miralax power17mg, and poured away all pink medication (metoprolol 50 mg) during medication administration through g tube. LNV U left a substantial amount of white medication the portion cup after the medication was administered through g tube to Resident #1 These failures could place residents at risk for increased negative side effects, and a decline in health. Findings included: Record review of Resident #223's face sheet dated 06/13/24 revealed an [AGE] year-old female was admitted on [DATE]. Resident #223 had diagnoses which included: chronic obstructive pulmonary disease (lung disease causing restricted airflow and breading problems), hypertension (when the pressure in the blood vessels is too high), and heart failure (heart does not pump enough blood for the body's needs). Record review of Resident #223's MAR dated June 2024 reflected in part . Albuterol sulfate inhalation nebulization (2.5mg/3ml) 0.085% . special instructions: via nebulizer three times a day for (COPD) start date 06/08/24 . Record review of Resident #223's Physician order dated June 2024 reflected in part . Albuterol sulfate inhalation nebulization (2.5mg/3ml) 0.085% . special instructions: via nebulizer three times a day for (COPD) start date 06/08/24 . During an observation on 6/12/24 at 9:10 a.m., revealed LVN U administered albuterol sulfate inhalation breathing treatment (2.5mg/3ml) 0.083% through a nebulizer to Resident #223. There was barely any mist from the machine, administered for 35 minutes. Then LVN U took the mask from Resident #223's face and stated he had finished administering the medication. The mask chamber still had 95% of the medication left in it. LVN U said he would pour the medication out in the restroom sink. LVN U stated Resident #223 did not get all of the medication. LVN U poured the medicines into the sink. (continued on next page)

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Arbor Hills Rehabilitation and Healthcare Center	535 S Austin Road Eagle Lake, TX 77434

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/24 at 1:09 p.m., the DON said the chamber of the breathing treatment mask should empty after LVN U administered the breathing treatment between 15 and 20 minutes to Resident #223. The DON said LVN U should have assessed the machine or gotten help to find out why there was medication left in the chamber instead of pouring the medication away. The DON said if a substantial amount of the breathing treatment were left in the chamber, the medication would not be effective because Resident #223 did not receive all her medication. The DON said the nurse managers (DON and ADON) monitored the nurses during rounding. During an interview on 06/12/24 at 2:43 p.m., LVN U said Resident #223 did not receive the correct dosage ordered because some of the medication was left in the mask chamber. LVN U said the medication would not be effective for the intended treatment. LVN U said he had a skills check on medication administration, and it included breathing treatment. LVN U said the DON or ADON monitors the nurses during rounding. 2. Record review of Resident #1's face sheet dated 06/13/24 revealed an [AGE] year-old female initially admitted on [DATE] and readmitted to the facility on [DATE]. Resident #1 had diagnoses which included: hypertension (when the pressure in the blood vessels is too high), gastrostomy (a tube inserted through the wall of the abdomen directly into the stomach), heart failure (heart does not pump enough blood for the body's needs) and cerebral infarction (damage to the brain tissue caused by a disruption in the blood flow to the brain). Record review of Resident #1's physician order dated June 2024 reflected in part . Miralax powder 17gm/scoop PEG - Tube one tome a day; gastric tube . special instructions: constipation start date 02/09/23 . metoprolol tartrate tablet 50mg; amount 1 tablet every 12 hours; gastric tube special instructions: hypertension . Record review of Resident #1's MAR dated June 2024 reflected in part . Miralax powder 17gm/scoop PEG - Tube one tome a day; gastric tube . special instructions: constipation start date 02/09/23 . metoprolol tartrate tablet 50mg; amount 1 tablet every 12 hours; gastric tube special instructions: hypertension . During an observation on 06/13/24 at 7:40 a.m., revealed LVN U inserted the syringe into the pot, which he said was for medication administration. LVN U poured 60 ml of Miralax into the syringe without flushing the g tube. The Miralax would not flow down, and while he was trying to milk the g tube tubing, the syringe came out of the pot, and 30 ml of Miralax poured on the resident's gown and blanket. The ADON entered Resident #1's room while LVN U was still administering the medication. When LVN U was administering the pink medication, the syringe fell out of the pot, and the medication poured away. When he finished administering the medication, revealed one of the portion cups had a substantial amount of white medicine left in the cup. The ADON observed the portion cup and said a lot of medication residue was left in the cup. During an interview on 06/13/26 at 8:24 a.m., the ADON said she observed the pick medication, which poured away, and the portion cup, which had a lot of medication residue. The ADON said if some of the Miralex spilled, it meant Resident #1 did not get the medications as ordered, which was a medication error, and the medications would not be effective. The ADON said the DON, and she monitored nurses during rounding. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/24 at 9:29 a.m., LVN U said some of the marlax spilled, and the metoprolol was the pink medication (metoprolol tartrate 50mg), which was poured away during administration. LVN U said one of the portion cups had a significant amount of white medication residual, which meant the resident did not get the required amount of medication prescribed for Resident #1. LVN U said the medicines would not be effective for treating the condition in which the medications were supposed to be treated. LVN U said the DON and the assistant DON monitored the nurses when they made rounds. During an interview on 06/13/24 at 9:50 a.m., the DON said if Resident #1 did not get a full dose of her medications as was ordered by the physician, then it was a medication error, and the medicines would not be effective. The DON said the nurse managers monitored the nurses during rounding. Record review of the facility medication administration dated 2001 MED - PASS, Inc (Revised April 2019) reflected in part . Medications are administered in a safe and timely manner, and as prescribed . Record review of facility policy on administering medications through an enteral tube dated January 2023 reflected in part . Purpose . the purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . Record review of the facility nebulizer competency created 1.25.2023 reflected in part . Continue this inhalation technique until all medication in the nebulizer cup has been aerosolized (usually about 15 minutes) .

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 36918 Based on observation and interview, the facility failed to ensure that drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles for 1 Station 1 nurse's cart) of 2 nurse medication cart and 1(Station 1 medication room) of 2 medication room reviewed for medications. -1 of 2 nurse medication cart (station 1) had 1 expired medication, breathing treatment opened and not dated opened breathing treatments with expired open dates. -1 of 2 medication rooms (medication room) had breathing treatments stored in a temperature above manufacturer's required temperature. These failures could affect residents, placing them at risk for altered effectiveness of the medication and worsening of the resident's symptoms, requiring medical intervention. The findings include: During an observation on 06/12/24 at 2:08 p.m. of nurse medication for station 1 medication cart with the ADON revealed the following: a blister packet of ondansetron HCL 4mg and it 8 tablets and it was expired on 04/29/24. 2 Fluticasone prop 50 mcg, 2 spray both nostrils was open but was not dated with open date or discard date. opened Budesonide inhalation suspension foil was not dated. opened albuterol sulfate inhalation solution 0.83% 2.5mg/3ml was opened on 04/29/24. ipratropium bromide 0.5mg/albuterol 3mg inhalation opened 05/15/24. During an interview on 06/12/24 at 2:20 p.m., the ADON said the nurses are responsible for pulling expired medications from the cart to prevent the medication from being administered to residents. The ADON stated the potency of the drug would have been reduced and it would not be effective for the required treatment. The ADON said the breathing treatments and inhalers should be dated when open because they have a different shelf life from unopened foil. The ADON said nurses should not administered medication past the required opened date because the medication would not be effective. The ADON said she would found out the self-life of opened albuterol sulfate inhalation and ipratropium and get back to the surveyor. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/24 at 2:25 p.m., the ADON said combination breathing treatment was good for one week when the foil was opened and two weeks for non-combined breathing treatment. The ADON said the open foil for the breathing treatments had expired because the date on the opened box foil exceeded the required open date. During an interview on 06/12/24 at 2:38 p.m., LNV U said the inhalation packet and nasal spray should be dated when the nurse opened the packet because it had a duration of effectiveness once opened. LVN U said if the medication were not dated and was administered to the resident after the opened date had expired, the medication would not be effective. LVN U said once a resident's medication expired, the nurse should had removed the medication from the cart which prevented the nurse from administrating the expired medicines to the resident because it would not be effective or might cause a negative outcome for the resident. LVN U did not answer why the expired medication was not removed from the medication cart. LVN U said he was trained in medication administration and storage. LVN U said the DON or ADON monitored the nurses when they made rounds. During an observation on 06/12/24 at 3:13 p.m., the Maintenance Director checked the medication room temperature at station 1, which was 81 degrees according to the infrared thermometer. During an observation of the medication room storage on 06/12/24 at 3:30 p.m. with the ADON revealed the following medications were stored above the manufacturer-suggested temperature in the medication room: 3 boxes of albuterol, 2 boxes of albuterol and ipratropium bromide 1 albuterol sulfate inhalation 1 Advair diskus 1 box of budesonide inhalation During an interview on 06/12/24 at 3:51 p.m., the DON said the medications were(3 boxes of albuterol, 2 boxes of albuterol and ipratropium bromide, 1 albuterol sulfate inhalation, 1 Advair diskus, and 1 box of 1 budesonide inhalation wrapped in foil and kept at the manufacturer's suggested temperature to preserve its effectiveness. The DON said if the medication was administered to residents when it was not stored appropriately, then the medication would not be effective. During an interview on 06/13/24 at 1:16 p.m., the Administrator said she did not know when the A/C in station 1 stopped working, and it may be about a week or so. The administrator said the A/C company they usually use was backed up. The administrator said she made an emergency call last night (06/12/24), and another company came out last night, and they could not fix it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/24 at 2:00 p.m., the Maintenance Director said the A/C in section 1 went out about three weeks ago. The maintenance director said the corporation reached out to another A/C company, which came out yesterday (06/12/23), but they could not fix it because the compressor was broken and had to be replaced. Record review of the facility storage medication dated 2001 MED - PASS, Inc. (Revised April 2019) read in part . the facility stores all drugs and biologicals in a safe, secure, and orderly manner .policy interpretation and implementation . #1. Drugs and biologicals are stored .under proper temperature .#5 . outdated are returned or destroyed . Record review of the albuterol sulfate inhalation aerosol box read in part . store at 68 to 77 degrees Fahrenheit please visit . https://lupin.com/abbterol . Record review of the storage direction on the Advair Diskus read in part . store at room temperature between 68 and77 degrees Fahrenheit . Record review of the storage direction on budesonide read in part . store at room temperature between 68 and77 degrees Fahrenheit . Record review of the storage direction on budesonide read in part . store at room temperature between 68 and77 degrees Fahrenheit . Record of https://www.nephronpharm.com/sites/default/files/products/package-inserts/Albuterol_Sulfate_0_083-Package%20insert.pdf read in part . store albuterol sulfate inhalation solution 0.83%between 36 and 77degrees . Record of https://www.hdrxservices.com/did-you-know-nebulizer-storage-recommendations/ read in part . expiration date once foil pouch is opened was 7 days .

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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** 35822 Based on observation, interview, and record review the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection for 1 of 8 residents (Resident #120) reviewed for infection control during care in that: -The NF failed to label and store resident personal care items that were in the bathroom of a semi-private room. -The NF failed to keep Resident #120's Foley catheter off the floor. These failures placed residents at risk for cross contamination, infections, and decease in quality of life. Findings: Record review of Resident #120's face sheet dated [DATE] revealed a[AGE] year old female admitted to the NF on [DATE] with the following diagnoses that included: urinary tract infection, anemia (low red blood cell count), gastrointestinal hemorrhage (bleeding), hypothyroidism (gland in the body that does not produce hormones to regulate important body functions), hypokalemia (low potassium), neuromuscular dysfunction of bladder (nerves and muscles of the balder do not communicate properly with the brain) and, hypertension (high blood pressure). Record review of Resident #120's Physician Orders for the Month of [DATE] reflected the following: -Dated [DATE] Foley catheter 16 fr 10 cc bulb -Dated [DATE] Foley catheter care Q shift and PRN Record review of Resident #120's baseline care plan dated [DATE] revealed that resident was being care planned for indwelling catheter r/t neurogenic bladder. The interventions included the following: Monitor/record/report to MD for s/s of UTI. Observation on [DATE] at 8:42AM in room [ROOM NUMBER]-A revealed Resident #120 awake in bed with the call light in reach. Further observation revealed the resident had a Foley catheter and the Foley bag was on the floor on the right side of the bed. Observation was made in the bathroom and on top of the counter was a small tube of toothpaste, bottle of shampoo cleanser, secret deodorant, can of shaving cream, and a gray wash basin all with no name of it. Resident #120's roommate was not in room. Interview on [DATE] at 8:45AM Resident #120 said the personal care items in the bathroom did not belong to her and that she did not know who the items belong to. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 9:05AM with CNA Z said she was the CNA for Resident #120. CNA Z said the resident's Foley catheter should not be on the floor for infection control . CNA Z said all resident's personal care items should be labeled and placed inside of a plastic bag to avoid cross contamination. CNA Z could not explain why Resident #120's Foley bag was on the floor. Interview on [DATE] at 2:00PM the DON said resident personal care items should be labeled with resident's name and stored in a plastic bag to avoid cross contamination. The DON said the staff was aware of that. The DON said if a Foley catheter bag was found on the floor, the CNA should report this to the nurse so that the nurse can change the Foley bag to avoid placing residents at risk for infections. Record review of the NF Infection Prevention and Control Program revised [DATE] revealed in part: An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections.