STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676369	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hollymead	4101 Long Prairie Road Flower Mound, TX 75028

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents had physician's orders for the residents' immediate care for 2 (Resident #402 & Resident #67) of 16 residents observed for physician orders for oxygen. 1. The facility failed to provide physician orders for Resident #402 when admitted to the facility with a need for oxygen and while resident was on 4L of oxygen via nasal cannula on 11/8/24. 2. The facility failed to obtain orders for colostomy care for Resident #67 on 3/10/25 These failures could place the residents at risk of not receiving necessary physician ordered care that could result in worsening conditions or decline in health. Findings included: 1-Review of Resident #402's Face Sheet dated 4/23/25 reflected that resident was a [AGE] year-old female admitted on [DATE] and discharged to the hospital on [DATE]. Relevant diagnoses included morbid obesity, heart failure (a chronic condition in which the heart doesn't pump blood), acute and chronic respiratory failure with Hypoxia (a condition in which the body doesn't receive enough oxygen), shortness of breath, and Pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid). Review of Resident #402's MDS assessment dated [DATE] reflected that Resident #104 had moderate cognition with a BIMS score of 12. Resident admitted to the facility with intermittent oxygen therapy and oxygen treatment was performed while Resident #402 was at the facility. Review of Resident's #402's Baseline Care Plan dated 10/31/2024 reflected no documentation of Resident #402's oxygen therapy treatment . (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #402's physician orders dated on 4/23/2025 reflected no physician orders for continuous and/or as needed oxygen supplement. Review revealed no physician order for when to change the cannula and oxygen tubing. Review of Resident #402's Patient Medication Summary on 4/23/2025 reflected no physician orders to keep the oxygen cannula and tubing in a bag when not in use. Review revealed no physician orders for when to change the humidifier. Review of Resident #402's Patient Medication Summary on 4/23/2025 reflected no physician's order to wash filters from oxygen concentrator. Review revealed no physician order for what to assess, like redness to nares (openings of the nose where the prongs of the cannula are inserted). Review of Resident #402's progress note dated 11/8/24 at 12:23pm Resident was assessed per request of nurse as she stated SOB (shortness of breath) and wanted to go to the ER (emergency room). O2 (oxygen) was 91% on 4L (liters) NC (nasal cannula) with RR20(respiration rate 20), resi dent was breathing out of her mouth and stated her nose felt stuffy. Changed to mask and increased O2 to 6L (liters)and O2(oxygen) increased to 93-94%. Pulmonary Nurse Practitioner was contacted and had a telehealth visit with resident with new orders to increase O2 to 5-6L In an interview with LVN I on 4/24/25 at 9:33am revealed if a resident needed oxygen, they had to review the standing orders to determine how many liters to give, if there was no standing order for oxygen they would call the doctor for an order. If a resident came to the facility with oxygen, they would give oxygen based on the hospital discharge order and would enter it in the system. There should always be an order for oxygen if it is being given. The risk to a resident would be hyperoxygenation that can negatively impact their respiratory system. In an interview with LVN H on 4/24/25 at 9:48am revealed when a resident needed oxygen, they needed to make sure orders were in their chart. When a resident was admitted with oxygen, they also needed to make sure there was an order. There should always be an order for oxygen if the resident required it. The risk to the resident not having an order for oxygen and the resident receiving oxygen, it could cause the resident to have respiratory issues. In an interview with ADON G on 4/24/25 at 10:07am revealed when a resident was admitted with oxygen, they would review orders, would take vitals and complete head to toe assessment. They would get a concentrator and items necessary for the order. They would enter the order in the resident's chart, to include number of liters and route. They would administer oxygen according to physician's order. All residents who need oxygen should have an order in the system. Oxygen would usually be included on the care plan. In an interview with RN A on 4/24/25 at 10:44am revealed most residents should have had a standing order for oxygen, typically 2 to 3 liters for emergencies. If a resident came to the facility with oxygen the nurses would ensure that an order was on file. If a resident needs oxygen daily or intermittently there should have been an order in the file. Oxygen should have also been included in the Care Plan. The risk to the resident of not having had an order for oxygen and getting oxygen was that the resident can have severe respiratory issues. In an interview with LVN D on 4/24/25 at 11:02am revealed when a resident was admitted to the facility with oxygen, there must be an order in the system for oxygen. If there is not order, he would notify the doctor at admission that the resident has admitted and has a need for oxygen and would get an order for it. The need for Oxygen would have been in the Care Plan. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview with MDS on 4/24/25 at 12pm who revealed she was unsure if the need for oxygen should have been on a baseline care plan but the need for oxygen should be on a care plan. If the resident needs oxygen there should have been an order and she proceeded to look for an order for Resident #402 in both their electronic systems. She was unable to find an order for oxygen for Resident #402 . She stated the risk to the resident of not having oxygen on the care plan would be that the resident would not get the right care. The care informed staff on the resident's needs. In an interview with DON on 4/24/25 at 1:35pm revealed the Baseline Care Plan is completed within 24 hours of admission and would have oxygen listed if the resident admitted with oxygen. There should have always been an order for all residents who required oxygen. The risk to the residents of not having had the proper order on record could be Hypoxia. In an interview with Administrator on 4/24/25 at 2:56am revealed the only time oxygen should have been administered to a resident was if the patient was crashing and it was an emergency, otherwise there would have had to be on order on file to administer oxygen. Review of the Facility's Oxygen Administration policy revised October 2010 revealed The purpose of this procedure is to provide guidelines for safe oxygen administration .1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident . 2-Record review of Resident #67's 03/14/25 Quarterly MDS, reflected he was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of heart failure, chronic kidney disease, acute respiratory failure (lung failure). He had intact cognition with a BIMS score of 14. Review of Section H- Bladder and Bowel reflected he was not noted to have an ostomy (a surgically created opening on the abdomen to allow waste to exit the body). Record review of Resident #67's 03/03/25 Discharge MDS reflected he had an ostomy appliance. Record review of Resident #67's care plan reflected a focus area of The resident has an alteration in gastrointestinal status r/t (due to) colostomy (a surgically created opening on the abdomen to allow waste to exit the body) with the interventions to give medications as ordered and monitor/document side effects and effectiveness, dated initiated 01/31/25. Record review of Resident #67's active order summary report, dated 04/24/25, reflected there were no orders regarding his colostomy care. Record review of Resident #67's Treatment Administration Record (TAR) for March 2025 revealed an order for colostomy care- change pouch/appliance one time a day with a start date of 02/26/25, discontinue date of 03/10/25 and marked as completed on 03/01/25 and 03/02/25 and not marked as provided on from 03/11/25-03/31/25. Further review revealed an order for Colostomy- Check placement and Empty Contents every shift to ensure it is secured. Empty Contents shift (every shift) and more often as necessary, with a start date of 02/04/25 and discontinue date of 03/10/25. In an interview and observation on 04/22/25 at 11:36 AM with Resident #67 revealed he had a colostomy pouch since around February of 2025 that staff changed daily and he was also able to change it himself. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/24/25 at 9:06 AM with LVN H revealed Resident #67 had a colostomy pouch that was changed by nurses daily and sometimes twice a day. LVN H reviewed Resident #67's orders and stated he did not see an order for Resident #67's colostomy pouch care and he must have missed that it was not in the TAR when Resident #67 readmitted to the facility in 3/10/25. He stated it was routine to change Resident #67's colostomy bag at least once a day and must not have noticed the order was not in the TAR. He stated that nurses were responsible to enter the resident orders when they are admitted to the facility. An interview on 04/24/25 at 4:08 PM with the DON revealed Resident #67 should have a physician order for colostomy care and should have been care planned. She stated she was not sure why it had been missed when Resident #67 readmitted on [DATE] and thought it was due to their electronic medical record's transfer from one system to a new system at the end of February 2025. She stated it was important to have physician orders for colostomy care to ensure a resident received the services they needed. Review of the facility's policy Physician's Orders revised January 2020. .Procedure: 1. All physicians' orders shall be recorded on the Patients Medical Record and must be signed electronically by the attending/prescribing physician .3. Physician orders include: a. All medications, b. Treatments, C. Diets, d. Restorative Measures (long-term and short term), e. Special medical procedures required for the safety and well being of the Patient, f. limitations of activities and g. Others as necessary and appropriate .5. Medications, diets, therapy or any treatment may not be administered to the Patient without a written order from the attending physician.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure the MDS assessment accurately reflected the resident status for 2 (Resident #71 and Resident #67) of 8 residents whose records were reviewed for assessment accuracy. 1. Resident #67's colostomy status was not coded on his 03/14/25 Quarterly MDS after readmission on [DATE]. 2. Resident #71's attention deficit hyperactivity disorder diagnosis was not listed on his 03/05/25 Quarterly MDS. This failure to ensure comprehensive and accurate assessments could affect residents by placing them at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Findings included: 1-Record review of Resident #67's 03/14/25 Quarterly MDS, reflected he was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of heart failure, chronic kidney disease, acute respiratory failure (lung failure). He had intact cognition with a BIMS score of 14. Review of Section H- Bladder and Bowel reflected he was not noted to have an ostomy (a surgically created opening on the abdomen to allow waste to exit the body). Record review of Resident #67's 03/03/25 Discharge MDS reflected he had an ostomy appliance. Record review of Resident #67's care plan reflected a focus area of The resident has an alteration in gastrointestinal status r/t (due to) colostomy (a surgically created opening on the abdomen to allow waste to exit the body) with the interventions to give medications as ordered and monitor/document side effects and effectiveness, dated initiated 01/31/25. In an interview on 04/22/25 at 11:36 AM with Resident #67 revealed he had a colostomy pouch since around February of 2025 that staff changed daily and he was also able to change it himself. An interview on 04/24/25 at 11:47 AM with the MDS Coordinator revealed Resident #67's ostomy status should have been selected on his 03/14/25 Quarterly MDS and was not sure why it was not selected. She stated Resident #67's 03/03/25 Discharge MDS indicated he had an ostomy appliance, and it must have been missed when he returned. She stated it was important for MDS assessments to be accurate to ensure a resident received the proper services they needed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2-Record review of Resident #71's Quarterly MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of paraplegia (paralysis of legs), diabetes (high blood sugar), and a BIMS score of 15 (intact cognition). Record review of Resident #71's care plan reflected a focus area, dated initiated 01/31/25, that indicated he used anti-anxiety medication due to an anxiety disorder with the interventions of monitoring for side effects and effectiveness. Further review revealed a focus area of the resident had potential to be verbally aggressive and yelled at staff due to ineffective coping skills, dated initiated 03/23/25, with the interventions of assess resident's coping skills and support system and administer medications as ordered. Record review of Resident #71's psychological subsequent assessments, dated 02/14/25 revealed resident had the diagnoses included generalized anxiety disorder and attention deficit hyperactivity disorder. In an interview on 04/23/25 at 12:17 PM with Resident #71 revealed he had the diagnosis of attention deficit hyperactivity disorder since he was 6 years old and received psychological services at the facility. In an interview on 04/23/25 at 2:07 PM with the Social Services Director revealed Resident #71 had a diagnosis of attention deficit hyperactivity disorder and received psychological services at the facility. She stated that the physician should have added the diagnosis to the resident's electronic health record and was not sure why it was missed. She stated it was important to have residents' diagnoses in the MDS and electronic health record to ensure residents received any needed services. In an interview on 04/24/25 at 9:06 AM with LVN H revealed he was aware that Resident #71 had a diagnosis of attention deficit hyperactivity disorder and was not aware it was not listed as one of his diagnoses on his MDS or on his factsheet . An interview on 04/24/25 at 11:47 AM with the MDS Coordinator revealed Resident #71's diagnosis of attention deficit hyperactive disorder was not in his 03/05/25 Quarterly MDS. She stated that she was not sure why it was not added to the resident's diagnoses, and it was important to have all current diagnoses accurately noted in the resident's MDS because it guides the plan of care and provided insight into each resident's needs. An interview on 04/24/25 at 4:08 PM with the DON revealed Resident #67 should have a physician order for colostomy care and it was care planned. She stated she was not sure why Resident #67's ostomy status had been missed when he readmitted to the facility in March 2025. She stated it was important to have physician orders for colostomy care to ensure a resident received the services they needed. She stated she was aware that Resident #71 had a diagnosis of attention deficit hyperactivity disorder and anxiety disorder and received psychological services. She stated the diagnosis of attention deficit hyperactivity disorder should have been listed as a diagnosis to ensure he received the correct care and services. She stated that the facility had changed its electronic health record system to another documentation programan and may have been missed in the transfer. She stated it was the responsibility of nursing to ensure resident diagnoses were updated during readmission and admission. She stated it was the responsibility of the MDS Coordinator to ensure assessments were complete. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's resident assessment policy, titled Resident Assessments, dated March 2022, reflected: A comprehensive assessment of every resident's needs is made at intervals designated by OBRA (Omnibus Budget Reconciliation Act) and PPS (Prospective Payment System) requirements .

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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** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 6 of 16 residents (Residents #67, #71, #36, #97, #401, #66) reviewed for care plans. 1. The facility failed to develop a comprehensive person-centered care plan regarding Resident #71's attention deficit disorder diagnosis. 2. The facility failed to ensure Resident #36's comprehensive care plan included a plan of care for ADL dependence including fingernail care. 3. The facility failed to ensure Resident #97's comprehensive care plan included a plan of care for Diagnosis of diabetes and insulin dependence. 4. The facility failed to develop and implement a care plan that reflected Resident #401 need for fall interventions after his initial falls on 3/14/2025. 5. The facility failed to develop and implement a comprehensive care plan that reflected Resident #66's measurable objectives, interventions, and timeframes for how staff would meet Resident #66's needs . This deficient practice could place residents at risk of not receiving the necessary care or services. Findings included: 1-Resident #71 Record review of Resident #71's Quarterly MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of paraplegia (paralysis of legs), diabetes (high blood sugar), and a BIMS score of 15 (intact cognition). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #71's care plan reflected a focus area, dated initiated 01/31/25, that indicated he used anti-anxiety medication due to an anxiety disorder with the interventions of monitoring for side effects and effectiveness. Further review revealed a focus area of the resident had potential to be verbally aggressive and yelled at staff due to ineffective coping skills, dated initiated 03/23/25, with the interventions of assess resident's coping skills and support system and administer medications as ordered. Record review of Resident #71's psychological subsequent assessments, dated 02/14/25 revealed resident had the diagnoses included generalized anxiety disorder and attention deficit hyperactivity disorder. In an interview on 04/23/25 at 12:17 PM with Resident #71 revealed he had the diagnosis of attention deficit hyperactivity disorder since he was 6 years old and received psychological services at the facility. In an interview on 04/23/25 at 2:07 PM with the Social Services Director revealed Resident #71 had a diagnosis of attention deficit hyperactivity disorder and received psychological services at the facility. She reviewed Resident #71's care plan and stated he did not have attention deficit hyperactivity disorder care planned. She stated that nursing and the MDS nurse were responsible for care planning, and it was important to care plan resident diagnosis to ensure their needs are met. In an interview on 04/24/25 at 9:06 AM with LVN H revealed he was aware that Resident #71 had a diagnosis of attention deficit hyperactivity disorder and was not aware it was not care planned. He stated care plans were important because they guided the plan of care for residents. An interview on 04/24/25 at 11:47 AM with the MDS Coordinator revealed Resident #71's diagnosis of attention deficit hyperactive disorder was not care planned. She stated that it looks like the physician did not enter the diagnosis into their electronic system, so it did not trigger a care plan on the facility side and it was not caught during the MDS look back periods. She stated it was important to care plan Resident #71's diagnosis because it provided more information and insight into his needs. She stated the ADON, MDS, and DON were responsible for care planning resident needs . An interview on 04/24/25 at 12:29 PM with the DON she stated she was aware that Resident #71 had a diagnosis of attention deficit hyperactivity disorder and anxiety disorder and received psychological services. She stated the diagnosis of attention deficit hyperactivity disorder should have been care planned. She stated care plans were important to guide the care of the resident. 2-Resident #36 Record Review of Resident #36 Quarterly MDS, dated [DATE], reflected that Resident #36 was a [AGE] year-old male admitted to facility on 02/24/2023 with BIMS Score of 13 that indicates Resident #36 had intact cognition. Resident #36 had diagnoses of Heart failure, Anxiety, Renal insufficiency (condition in which kidneys lose the ability to remove waste and balance fluids), Limitation of activities due to disability. It also indicated Resident #36 was dependent on staff for personal hygiene. Record Review of Resident #36 Comprehensive care plan dated 4/24/25 revealed Resident #36 did not have a care plan for ADL assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation with Resident #36 revealed his fingernails on both his hand were at least 0. 75 inch - 1 inch long. It also revealed Resident #36 had slight contracture on right middle finger. Resident #36 stated he would like staff to trim his fingernails since he cannot cut his own nails. He stated staff had not approached him lately to cut his nails. 3-Record Review of Resident #97 MDS dated reflected Resident #97 was a [AGE] year-old female admitted to facility on 04/02/2025 with BIMS Score of 3 that indicates Resident #97 had severe cognitive impairment. Resident # 97 had diagnoses of Hypertension (high blood pressure), Diabetes Mellitus (high blood glucose) , Hyperlipidemia (high blood lipids), Non-Alzheimer's Dementia, Acute Pancreatitis without necrosis (a condition where the pancreas becomes inflamed but without death of the pancreatic tissues). It also reflected Resident #97 had Insulin injections during the last 7 days or since admission. Record review of Resident #97 Physician order dated 4/21/25 reflected, Humalog Injection Solution 100 Unit/Milliliters; Inject as per sliding scale subcutaneously (applied under the skin) four times a day for [Diabetes]. Record review of Resident #97 Physician order dated 4/3/25 reflected, Insulin Glargine Solution 100 Unit/Milliliters; Inject 10 unit subcutaneously (applied under the skin) at bedtime for diabetes. Record Review of Resident #97 Comprehensive care plan dated 4/24/25 revealed Resident #97 did not have a care plan for Diagnosis of diabetes or insulin dependence. In an interview on 04/24/2510:11 AM with LVN D revealed Nurses, ADONs and DONs were responsible for care planning. He stated that care planning should be tailored to resident's specific needs, and it was important to care plan accurately so that residents care needs were met. He stated that Resident #36 liked to be independent, however he needed assistance with ADLs specifically with nailcare related to his disability. In an interview on 04/24/25 at 11:20 AM CNA J revealed Care plans were important since they provide information about Residents care needs and the dos and don't's. She stated that CNAs were not involved with care planning, however the risk of not care planning resident care needs may lead to failure to provide care for the resident. In an interview with the DON on 4/24/25 at 09:55 AM revealed Resident # 36 was dependent on staff for ADL and Resident #97 was dependent on insulin related to Diagnosis of Diabetes. The DON stated every resident should have a plan of care that is personalized for their care. She stated the MDS Coordinator, ADONS and DON were responsible for writing the care plans and risk of not care planning could lead to failure to provide personalized care to residents. In an interview on 04/24/25 at 02:09 PM with ADON G stated that Resident #36 should have ADL dependence on staff care planned. She also stated that Resident #97 had diagnosis of diabetes and was receiving insulin injections daily. She stated that MDS Nurses, ADONs and DONs were responsible for completing and updating care plans as needed. She stated the risk of not care planning was failure possibility of residents not getting care or assistance they need, and quality of life could be affected. 4-Resident #401 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #401's admission Minimum Data Set (MDS) Assessment, dated 3/17/2025, reflected she was a [AGE] year-old male with an admission date of 3/13/2025. Resident #401 was moderately cognitively impaired, and his BIMS score was 9. He needed some help with self-care and required a walker. Resident had a history of falls with a fall in the last month resulting in injury. He had impairment to one side of his lower extremities. He had the following diagnosis: Hip fracture, other fracture and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of Resident #401's care plan revised on 4/7/2025 revealed Risk for Injury: Fall occurred 3/14, Fall occurred 3/16/25, Fall Occurred 3/18/25, Fall occurred 3/25/25 Date Initiated: 03/19/2025 .o Alert provider Date Initiated: 03/19/2025 Revision on: 04/07/2025 Cancelled Date: 04/07/2025 04/07/2025 o CANCELLED: Assess Resident and identify any injuries from fall Review pain management regimen for resident Date Initiated: 03/19/2025 Revision on: 04/07/2025 Cancelled Date: 04/07/2025 o CANCELLED: Consult physical therapy per order Date Initiated: 03/19/2025 Revision on: 04/07/2025 Cancelled Date: 04/07/2025 o CANCELLED: Determine and address causative factors of the fall Low Bed Fall Matts Room close to nurse station Date Initiated: 03/26/2025 Revision on: 04/07/2025 Cancelled Date: 04/07/2025 o CANCELLED: Follow facility post-fall policy Date Initiated: 03/19/2025 Revision on: 04/07/2025 Cancelled Date: 04/07/2025o CANCELLED: Assist Resident with ambulation and transfers, utilizing therapy Recommendations Date Initiated: 03/17/2025 Revision on: 04/07/2025 Cancelled Date: 04/07/2025 RN LPN o CANCELLED: If Resident is a fall risk, initiate fall risk precautions Date Initiated: 03/17/2025 Revision on: 04/07/2025 Cancelled Date: 04/07/2025 . Review of facility Accident/Incident Report for March 2025 revealed Resident #401 had falls on the following dates: 3/14/2025, 3/14/2025, 3/16/2025, 3/18/2025 and 3/25/2025. Interview with LVN H on 4/24/25 at 9:48 am revealed when a resident was a fall risk at admission, the interventions would have been put on the initial care plan and updated after every fall . Interview with RN A on 4/24/25 at 10:44 am revealed residents who were at risk of falling had the fall risk listed on their care plan immediately. The risk of not having fall risk on their care plan would be not staff would know of the fall risk, thus putting the resident at risk to fall. Interview with ADON G on 4/24/25 at 10:07 am revealed after every resident fall, staff would update the care plan. If the resident was a fall risk at admission, they would put fall risk and interventions in the initial care plan. As they got more information on the residents, they would update the interventions and care plan as needed. Initial care plans or Circle of Excellence (COE) were done within 72 hours of admission with each resident. Interview with MDS on 4/24/25 at 12:18 pm revealed that at the Interdisciplinary Teams meetings all falls of resident from the day before or overnight were discussed and then the DON would delegate someone to update the Care Plan of each resident who fell. She was unsure if the care plan was updated after every fall or the time frame they had to update the care plan after a fall. (continued on next page)

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	676369	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hollymead	4101 Long Prairie Road Flower Mound, TX 75028

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with DON on 4/24/25 at 1:35pm revealed that Resident #401 admitted to the facility with fall precautions. Their protocol was after each fall, they would talk about the fall as a team and discussed appropriate interventions. Resident #401 admitted with the following precautions: low bed, room close to nurses' station and listed as a fall risk by displaying a stamped leaf on the name plaque outside his room. The leaf on the plaque alerts all staff that he was at risk of falling. They added a scoop mattress after one fall, a fall mat at bedside after another fall and then had him in a chair in a common area during waking hours for maximum observation. The care plan for Resident #401 was not updated after every fall because some of the initial falls happened on the weekend when staff who update the care plan are off. His care plan was updated the following week when all staff returned to the facility. They tried to update Care Plans as quick as possible, but interventions discussed are implemented immediately. All staff were aware of the interventions and that Resident #401 was a fall risk because they had shift to shift conversations about Resident #401 after every fall and he had the leaf stamp on his door. There was no risk to the resident that his care plan was not updated timely because all staff knew . Interview with Administrator on 4/24/25 at 2:56pm revealed when a resident admitted into the facility as a fall precaution it would be on the careplan, and they would add other interventions in place that weren't already being used. Staff would put in new falls in the care plan by the next morning. 5-Resident #66 Record Review of Resident #66 MDS dated reflected Resident #66 was a [AGE] year-old male admitted to facility on 01/18/2025 with BIMS Score of 0 that indicates Resident #66 had severe cognitive impairment. Resident # 66 had diagnoses of Congestive heart failure, Diabetes Mellitus (high blood glucose), Atrial Fibrillation (an irregular heart rate), Bell's Palsy (sudden weakness in the muscles on one half of the face), and Hypertensive Heart Disease (high blood pressure damages the heart). Record review of the comprehensive care plan for Resident #66 indicated no comprehensive care plan was initiated. An interview on 4/24/25 at 4:30pm, the DON reviewed Resident #66's record and stated Resident #66 had no comprehensive care plan. Record Review of Facility policy titled, Care plans Comprehensive, dated September 2010, reflected: Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident

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F 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** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 4 residents (Resident #2, Resident #36, Resident #27, Resident #16) of 15 residents reviewed for ADLs. The facility failed to ensure: 1. Resident #2 had his nails cut and cleaned on 04/22/25. 2. Resident #36 had his nails trimmed on both hands on 04/22/25. 3. Resident #27 had her fingernails cleaned and trimmed on both hands on 4/22/25. 4. Resident #16 had her fingernails cleaned and trimmed on both hands on 4/22/25. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: 1- Resident #2 Record review of Resident #2's quarterly MDS assessment, dated 02/19/25, reflected a [AGE] year-old female with an admission date of 03/11/20. Resident #2 had BIMS score of 15 which indicated she was cognitively intact. She required substantial to maximum assistance for personal hygiene and had not refused care. She had functional limitation in range of motion both upper and lower extremities on one side. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). She had not received occupational therapy (therapy that focus on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days look back period. Record review of Resident #2's care plan dated 04/23/25 reflected, Self-care Deficit-Extensive assistance required with bathing, hygiene, dressing, and grooming related to Resident #2's Document Survey report for April 2025 did not list personal hygiene as a task to be provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 04/22/25 at 11:10 AM Resident # 2 was observed lying in bed. Her right hand had nails that were approximately ½ inches in length and had brown/black substance under all her nails. Her left hand was drawn up in a fist and resident was unable to open her left hand. Resident #2 stated she had a stroke and was not able to use her left hand. She stated her nails were long and needed cut and cleaned. She stated no one had offered to trim her nails or clean them. She stated she feeds herself and does not like how dirty her nails are. She stated her sister cut her nails the last time they were cut. In an interview and observation on 04/22/25 at 01:55 PM CNA B was observed in Resident #2's room heating up food the resident's family had brought for her. CNA B stated they were responsible for trimming residents' nails on shower days, or as needed. She stated the resident's shower days were on the 2:00 p.m. shift, but stated nails were to be cleaned and trimmed no matter what shift. She stated she had not noticed Resident #2's nails and stated the nails on her right hand were dirty. CNA B opened resident left hand gently revealing her nails to be 1 1/2 inches long and jagged. Inspection of her palm did not reveal any skin breakdown. CNA B stated they were very long and needed trimming. She stated the risk of not cleaning and keeping nails clean were infection. In an observation and interview on 04/22/25 at 02:01 PM RN A was observed at Resident #2's bedside to look at her nails. RN A stated the CNAs were to trim nails on shower days or as needed. She stated the Restorative Aide was also responsible for trimming nails. She observed Resident #2's nails and stated the nails on her left hand (contracted hand) need to be kept short to prevent skin breakdown. She stated the resident wanted her right-hand nails long, Resident #2 spoke up and stated she did not want them long. She stated when they got this long, she had trouble using her phone and they get dirty. RN A stated the risk of not keeping nails clean and trimmed were infection and skin breakdown with the contracted hand. 2- Resident #36 Record Review of Resident #36 Quarterly MDS dated [DATE] reflected that Resident #36 was a [AGE] year-old male admitted to facility on 02/24/2023 with BIMS Score of 13 that indicates Resident #36 had intact cognition. Resident #36 had diagnoses of Heart failure, Anxiety, Renal insufficiency (condition in which kidneys lose the ability to remove waste and balance fluids), Limitation of activities due to disability. It also indicated Resident #36 was dependent on staff for person hygiene. Record Review of Resident #36 Comprehensive care plan dated 4/24/25 revealed Resident #36 did not have a care plan for ADL assistance. In an Observation and Interview with Resident #36 revealed his fingernails on both his hand were at least 0. 75 inch - 1 inch long and jagged. It also revealed Resident #36 had slight contracture on right middle finger. Resident #36 stated he would like staff to trim his fingernails since he cannot cut his own nails. He stated staff had not approached him lately to cut his nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/23/25 03:39 PM with CNA F stated that CNAs were responsible for trimming fingernails on shower days and as needed. He stated that the Staffing Coordinator, who is also a CNA, sometimes helps with trimming nails. She added Resident #36 sometimes refused clipping his fingernails, however she had not made the Charge Nurse or DON aware of it. She stated untrimmed and jagged fingernails could cause skin irritation or infection. In an interview on 04/24/25 10:11 AM with LVN D revealed Resident #36 was dependent on staff for ADL care including nail care. He stated that CNAs and restorative aides were responsible for nail care, unless if the resident was diabetic, then LVN should be trimming nails. He stated that Resident #36 did not have diagnosis of diabetes and added Resident #36 liked to be independent, however needed assistance with ADLs specifically with nailcare related to his disability with right hand. He stated risk of long, jagged nails was possibly of infection and loss of quality of life. 3- Resident # 27 Record review of Resident #27's Comprehensive MDS assessment dated [DATE] reflected Resident #27 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included stroke (a loss of blood flow to part of the brain, which damaged brain tissue), and dementia (a group of thinking and social symptoms that interferes with daily functioning). Resident #27's BIMS score of 00, which indicated Resident #27's cognition was severely impaired. The MDS assessment indicated Resident #27 required maximal assistance with personal hygiene. Record review of Resident #27's Care Plan dated 03/19/25, reflected the following: Focus: [Resident has an ADL selfcare deficit . Goal: Resident will maintain current level of function . Interventions: . Check nail length and trim and clean . as necessary. Report any changes to the nurse . In an observation and attempted interview on 04/22/25 at 10:59 AM revealed Resident #27 was laying in her bed. The nails on both hands were approximately 0.4cm in length extending from the tip of her fingers. The nails were discolored tan on both hands. Resident #27's answers to questions did not make sense. In an interview on 04/22/25 at 11:09 AM, CNA K stated CNAs and nurses were responsible to clean and cut the residents' nails. CNA K stated did not notice Resident #27's nails. She stated she would do it right then. She stated the risk would be infection control and injury. 4- Resident #16 Record review of Resident #16's Quarterly MDS assessment dated [DATE] reflected Resident #16 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included diabetes mellitus, and dementia (a group of thinking and social symptoms that interferes with daily functioning). Resident #16's BIMS score of 04, which indicated Resident #16's cognition was severely impaired. The MDS assessment indicated Resident #16 required moderate assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #16's Care Plan dated 04/24/24, reflected the following: Focus: [Resident #16]'s ADL function: 1 person assist with ADLs . Goal: . will maintain a sense of dignity by being clean, dry, odor free, and well groomed . Interventions: . Assist as needed . In an observation and interview on 04/22/25 at 11:45 AM revealed Resident #16 was sitting in her bed. The nails on both hands were approximately 0.6cm in length extending from the tip of her fingers. The nails were discolored tan and had yellow greenish colored residue underside and on the nails' bed on the right hand. Resident #16 stated she did not like her fingernails long and dirty. In an interview on 04/22/25 at 11:50 AM, LVN L stated CNAs were responsible for trimming the nails of residents who were not diabetic, and nurses were responsible for trimming nails of residents who were diabetic. LVN L stated did not notice Resident #16's nails. She stated she would do it. She stated the risk would be infection control and skin breakdown. In an interview with the DON on 04/24/25 at 09:06 a.m. she stated nails were to be trimmed and cleaned on shower days. She stated in addition the Restorative aide as well as the Staffing Coordinator were to check residents' nails to ensure they were trimmed and cleaned. She stated she was very disappointed that any resident was found with dirty long nails, since there were assigned individuals responsible for ensuring the nails were kept trimmed and clean. She stated the risk of not cleaning and trimming nails were infection and poor hygiene. In an interview with the Staffing Coordinator on 04/24/25 at 10:00 a.m. she stated she was assigned as back up for the CNAs to trim and clean fingernails for the long-term care residents. She stated she had not trimmed Resident #2's nails because when she had gone in her room in the past, she would be asleep or ask her to come back later. She stated she had not reported to anyone she had not trimmed her nails; she just assumed the CNAs would take care of it. Record review of Facility policy titled, Care of Fingernails/ Toenails revised October 2010, reflected Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections Nail care includes daily cleaning and regular trimming .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for one of three (Resident #2) reviewed for range of motion. The facility failed to implement interventions to prevent further decline of Resident #2's contracture to her left hand on 04/22/25. This failure could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. Findings included: Record review of Resident #2's quarterly MDS assessment, dated 02/19/25, reflected a [AGE] year-old female with an admission date of 03/11/20. Resident #2 had BIMS score of 15 which indicated she was cognitively intact. She required substantial to maximum assistance for personal hygiene and had not refused care. She had functional limitation in range of motion both upper and lower extremities on one side. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). She had not received occupation therapy (therapy that focus on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days look back period. Record review of Resident #2's care plan with an initiation date 03/30/25 reflected, The Resident has a contracture to left hand. Upper/lower extremities, hand wrist foot and hip .Interventions .Use of supportive devices such as splints, braces, canes, crutches etc., as recommended by OT . Record review of Resident #2's revised care plan dated 04/23/2025, reflected, The resident has a contracture to left hand. She refuses the splint frequently .Intervention .Carrot splint(splint used to position fingers away from the palm of the hand) to be applied to left hand impairment every morning up to four hours on as tolerated .Educate resident on importance of applying splint .Monitor and repot to Nurse any change in skin integrity . Record review of Resident #2's of the CNAs task list dated 04/22/25 did not indicate splint placement or range of motion to be provided to Resident #2's left hand. Record review of Resident #2's Document Survey report for April 2025 reflected, Carrot splint to be applied to left hand impairment every morning up to four hours on as tolerated, with an effective date of 04/15/25 for the day shift. There was no documentation the splint was applied or refused from 04/15/25 through 04/22/25. On 04/23/25 the splint was applied, and the codes indicated the Resident participated and had tolerated it good. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 04/22/25 at 11:10 AM Resident # 2 was observed lying in bed. Her left hand was drawn up in a fist and resident was unable to her open her left hand. Resident #2 stated she had a stroke and was not able to use her left hand. She stated she used to have a splint for her left hand but had not seen it in a while. A blue hand/forearm splint was observed on her bedside chest of drawers and a carrot splint was hanging on her closet door. Resident stated she would sometimes have the staff put a washcloth in her hand at night. In an interview and observation on 04/22/25 at 01:55 p.m. CNA B gently opened Resident #2's left hand revealing her nails to be 1 1/2 long and jagged. Inspection of her palm did not reveal any skin breakdown. CNA B stated the resident's nails were very long and needed trimming. She stated she thought the Carrot splint was for her right hand to use for exercise. She stated she had only seen the resident use the other splint one time since she had been working here. She stated she had not been instructed on any splint placement or the use of the carrot splint for the resident. She stated she was not sure if the resident was on restorative care or not. She stated it was not on their task list for them to apply any splint or any range of motion exercises. In an interview with the OTR on 04/22/25 at 2:10 p.m. she stated she does not usually work in this building and was just helping today. She stated Resident #2 was on OT services from 01/23/25 through 01/30/25 but stated it does not appear they worked with her left hand. She stated she could screen her today and determine if they needed to put her back on services. In an observation on 04/22/25 at 02:15 p.m. the OTR was observed assessing Resident #2's left hand. During the assessment Resident#2 told the OTR that when she manipulated her thumb it hurt on her inner arm. The OTR stated the tendon was tight. She stated she would complete a new evaluation on her and determine if the resting splint (The blue hand/forearm splint) would still work for her. Record Review of Resident #2's OT assessment completed by the OTR on 04/22/25 reflected, .Initial Assessment .Orthotics- Splint/Orthotic (supportive devices used to correct, support, or protect body parts) Recommendations: comfy wrist/hand/finger orthosis- ordered today. This splint does not stretch the thenar eminence (the fleshy mound at the base of the thumb, formed by three small muscles that control thumb movement) so will trial this splint first . In an interview with the MDS on 04/23/25 at 9:35 a.m. she stated she was the Skilled MDS nurse and was also covering for long-term care resident since the position had been open for a while. She stated they do not have a restorative program, but stated they do have an aide that does some restorative on residents. She stated there was no specific restorative care plan but stated it should be on the comprehensive care plan and on the CNAs task list. She stated therapy would provide them a plan of care when a resident was coming off therapy. She stated Resident #2 was not currently listed on the restorative list. In an interview with the Restorative Aide on 04/23/25 at 09:40 a.m. she stated Resident #2 was not on her list for restorative. She stated she does not get a restorative care plan; she just gets a list from the DON on who she was supposed to work with and what they needed done. She stated she had attempted to put the splint on Resident #2 in the past, but stated the resident told her it hurt, so she did not put it on her. She stated she had not documented anywhere because she did not have access to the new system they have had since February. She stated she just got access this week to the new system. She stated she had not told anyone about the splint hurting the resident. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DOR on 04/23/25 at 12:40 p.m. who stated they do not have a contracture program, but stated they had a list of residents in the facility with contractures they screen quarterly. He stated the last time they had addressed Resident #2's left hand contracture was January 26, 2025, and they had provided her a carrot splint for her left hand because it was easier. He stated the facility had recently gone from one electronic record system to a different system in February 2025. He stated he could now add a restorative care plan. He stated Resident #2's care plan had been updated as of today (04/23/25) to reflect the placement of the carrot splint. He stated most of the communication prior was to the DON, ADON or Charge nurse and it was verbal. In an interview with the DON on 04/23/25 at 02:00 p.m. who stated they had all residents screened by therapy upon admission and any time there was a functional decline. She stated they do not have a restorative program, but Range of motion and splinting can be carried out by the nursing staff and the CNAs once therapy determines the need. She stated she had not been informed about Resident #2's refusing her splint or the change to the carrot splint. She stated therapy set ups the plan for what restorative needs the resident will require and communicates with the MDS nurse. She stated those needs would be placed on the task list for the CNAs to carry out. She stated anytime the resident was refusing any service the CNAs had to let the Charge Nurse and herself know. She stated the interventions needed to be care planned. She stated failing to implement interventions for residents with limited Range of motion could lead to worsening of a resident's contractures and decline in function. Review of the facility's policy titled, Restorative Nursing Services, dated July 2017, reflected, Residents will receive restorative nursing care as needed to help promote optimal safety and independence .Restorative nursing care consist of nursing interventions that may or may not be accompanied by formalized rehabilitative services .Resident may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. Restorative goals and objectives are individualized and resident-centered, and are outline in the resident's plan of care .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one (Resident #5) of two residents observed during a transfer. The Facility failed to ensure CNA K used a gait belt when transferring Resident #5 from her bed to the wheelchair on 04/22/2025. This failure could affect the residents by placing the residents at risk for falls, discomfort, pain, and/or injury. Findings included: Record review of Resident #5's Quarterly MDS assessment, dated 03/13/25, reflected an admission date of 11/29/23. Resident #5' active diagnoses included weakness and other abnormalities of gait and mobility. Resident #5 had a BIMS score of 06, meaning her cognition was severely impaired. she required maximal assist with transfers from a bed to a wheelchair. Record review of Resident #5's care plan, dated 03/19/25, reflected Focus .The resident has potential risk for injury due to unsafe independent transfers . Goal: The resident will be free from injury . Interventions included .to be transferred with assist of one and use of gait belt . An observation on 04/22/25 at 10:29 AM revealed CNA K provided incontinent care to Resident #5. CNA K assisted Resident #5 onto the side of the bed. CNA K placed the wheelchair next to the bed facing toward the head of the bed and locked the wheels. CNA K placed her feet outside of the resident legs and lifted her by her clothes from the back. She lifted her from the bed toward the wheelchair. CNA K held Resident #5 by the arm pits, and she assisted her to sit on the wheelchair. Resident #5 hollered ouch. Resident stated it hurt under the breasts. In an interview on 04/22/25 at 11:45 AM, CNA K stated she was supposed to use a gait belt when transferring residents. She stated not using a gait belt could lead to a fall, or she could injure herself. She stated she had been in serviced on gait belt transfers when she was hired. In an interview on 04/24/25 at 10:02 AM, the DON stated it was the expectation for staff to use a gait belt when providing transfers to residents to prevent the risk of injury to the resident and the staff. She stated they had issued gait belts to all the CNAs, and she expected them to always have the belts with them to use it. She stated going forward she would do skills check monthly and she would do her rounds for monitoring. Record review of the facility's policy, Using a Transfer Belt revised July 2014, reflected, Belt should be used on any patient who requires any type or level of assistance with transfers or ambulation .

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	676369	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hollymead	4101 Long Prairie Road Flower Mound, TX 75028

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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** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of two residents (Resident #1) reviewed for catheter care. 1. The facility failed to ensure CNA B provided catheter care and appropriate perineal care for Resident #1 when she failed to separate the labia and wash downward, failed to clean under the resident's skin folds and failed to clean around the suprapubic catheter (catheter that is inserted through the abdominal wall into the bladder) on 04/23/25. 2. The facility failed to ensure RN A maintained a sterile procedure while re-inserting Resident #1's suprapubic catheter on 04/23/25. This failure could place residents at risk for the development and/or worsening of urinary tract infections and skin breakdown. Findings included: Record review of resident #1s quarterly MDS assessment, dated 02/28/25, reflected a [AGE] year-old female with an admission date of 08/01/24. She had a BIMS score of 15 which indicated she was cognitively intact. She was dependent for toileting care. She had a foley catheter and was frequently incontinent of bowel. Active diagnoses included multiple sclerosis (disease that causes breakdown of the protective covering of nerves) and neurogenic bladder (disruption in the nervous systems connection to the bladder). Record review of Resident #1's Physician Order Summary report dated 04/24/25, reflected, Indwelling catheter care every shift with a start date of 02/04/25 and Suprapubic Catheter 18 F 10 bulb {18 French 10 bulb is the size of the catheter} as needed for occlusion or leakage as needed, with a start date of 04/23/25. Record review of Resident #1's care plan, initiated on 01/09/25, reflected, The resident has indwelling Suprapubic catheter .Goal-the resident will show no signs and symptoms of urinary infection .Interventions . monitor for signs and symptoms of discomfort on urination and frequency . In an interview and observation on 04/23/25 at 9:50 a.m. Resident #1 was lying in bed with a strong urine odor. Resident #1 stated she thinks her catheter is leaking and stated she hated the smell. Staff were called to Resident's room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/25 at 10:14 a.m. CNA B and Restorative aide entered Resident #1's room. Both staff washed their hands and put on gown and gloves. CNA B unfasted the resident's brief. Resident was noted to have redness extending out from under her belly folds. Resident had suprapubic catheter but unable to observe insertion site due to skin fold. CNA B wiped down each groin, revealing the Resident had a bowel movement that had pushed up between her legs. CNA B wiped to remove the bowel movement from the resident inner thighs, then wiped across the pubic mound but did not spread her labia and wipe down the middle. CNA B did not clean under the resident's skin folds or around the suprapubic catheter, which was leaking urine. Both staff rolled the resident onto her side, revealing the brief was saturated with urine and a large soft bowel movement. CNA B continued to clean from front to back until all bowel movement was removed. CNA B then removed her gloves, performed hand hygiene, and re-gloved before placing a clean brief under the resident. Restorative aide gathered the trash, removed her gloves and gowns, performed hand hygiene, and left the room. Observed RN A on 04/23/25 at 10:30 a.m. entered Resident #1's room with the catheter kit needed to change the suprapubic catheter. RN A washed her hands and put on utility gloves but did not put on a gown. RN A placed the catheter kit and foley catheter on the bed, put on utility gloves and deflated the balloon on the suprapubic catheter with a 10-cc syringe and then removed the catheter. Urine was noted running down the Residents side. CNA B opened a trash bag and RN A placed the old catheter and catheter bag, which was half full of urine, in the trash bag. RN A removed her gloves and washed her hands. CNA B asked if she was needed and RN A stated no. CNA B removed her gown and gloves, gathered the trash, performed hand hygiene, and left the room. RN A then opened the catheter kit and removed the packet containing sterile gloves. RN A then put on the sterile gloves without first sitting up her sterile field or opening the foley catheter. RN A placed the sterile drape on top of the resident legs and around the resident's lower abdomen. RN A reached into the catheter kit and opened the betadine swabs and lifted the residents belly fold to reveal the insertion site. RN A cleaned around the stoma site with the betadine swabs and then removed her sterile gloves. RN A washed her hands and put on utility gloves and opened the catheter package and opened a package of lubricant. She then picked up the catheter midway down, with approximately 3 inches of the catheter dangling and guided it into the packet of lubricant. RN A then proceeded to raise the resident belly fold and inserted the catheter approximately 3-4 inches until urine return. RN A then attached the syringe to the catheter port and inserted 10 cc of normal saline to inflate the [NAME]. The end of the catheter was left open to air and urine was noted draining onto the resident's side. RN A then connected the catheter to the urinary drainage bag. RN A then removed her gloves, disposed of the trash, and performed hygiene. She stated the aides would have to come back in and clean her up again since the urine had run down her side. In an interview with RN A on 04/23/25 at 10:45 a.m. she stated changing a catheter required sterile procedure to decrease the risk of infection. She stated she thought she had maintained a sterile procedure while changing Resident #1's catheter. In an interview with the DON on 04/23/25 at 02:00 p.m. she stated the CNAs were supposed to perform catheter care anytime they provided incontinence care to reduce the risk of infection. She stated they had to follow the proper procedure for incontinence care which included spreading the labia and wiping down the middle to ensure the residents were clean and help reduce infection risk. She stated RN A should have set up her sterile field up first to perform the catheter change. She stated once she removed her sterile gloves and put on utility gloves and then inserted the catheter with utility gloves, the procedure was no longer considered sterile. She stated she would re-educate her on catheter changes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the Facility's policy titled, Suprapubic Catheter-Insertion Of, dated June 2006, reflected, . Equipment-Sterile catheter insertion set, Sterile indwelling catheter, Sterile water for inflation of bulb, Sterile gloves .Procedure .Wash your hands .Peel back wrapper of catheter insertion set. DO NOT CONTAMINATE CONTENTS. Place on working surface. Open catheter if in separate packaging. Open sterile wrap to provide sterile filed. Put on sterile gloves. Place protective pad below opening for catheter. Open lubricating jelly and squeeze onto catheter tip. Use a clean cotton ball/swab stick for each cleansing, clean edges and skin around opening to catheter with antiseptic solution. Begin at edges of opening and cleanse in concentric circles moving outward. Clean directly over opening with last cotton ball/swab stick and antiseptic solution, taking care not to let solution run into opening. Gently without force, insert lubricated catheter into opening about one to one-half inches. Place other end of catheter into specimen container .Inflate balloon to capacity as stated on catheter. Attach catheter to drainage bag .Leave the Patient clean, dry and in comfortable position . Record Review of the Facility's policy titled, Perineal Care, dated October 2010, reflected, The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition .Wash and dry your hands .put on gloves .For female resident . Wash perineal area, wiping from font to back .Separate labia and wash area downward from front to back. (Note: if resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches .). Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes .Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks .Remove gloves .Wash and dry your hands .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, administering, and securing of medications for 3 medication carts (med aid cart hall400/500) of 4 medication carts reviewed for pharmacy services in that: The facility failed to ensure: 1- LVN D responsible for Nurses Cart Hall 300, removed medications in unsecure containers from the Nurses Cart. 2- LVN L responsible for Nurses Cart Hall 100, removed medications in unsecure containers from the Nurses Cart. 3- RN A responsible for Nurses Cart Hall 200, removed medications in unsecure containers from the Nurses Cart. These failures placed residents at risk of not receiving full dosage of medication, and place residents at risk of not having the medication available due to possible drug diversion, and place residents at risk of not receiving medications as ordered. Findings Included: 1- Record review and observation on 04/22/25 at 12:15 PM of Nurses Cart Hall 300, with LVN D revealed the blister pack for Resident #83's tramadol 50 mg tablet (controlled medication used for pain) had 2 blister seals broken and the pills still inside the broken blister. Interview on 04/22/25 at 12:23 AM, LVN D stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seals were broken, and she was not aware of who might have damaged the blisters. She stated the risk would be a potential for drug diversion. She stated the nurses were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would waist the pill with another nurse. 2- Record review and observation on 04/22/25 at 12:29 PM of Nurses Cart Hall 100, with LVN L revealed the blister pack for Resident #51's tramadol 50 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister and taped over. Interview on 04/22/25 at 12:32 AM, LVN L stated the count was done at shift change and the count was correct. She stated she did not see the damaged blister. She stated it was not allowed to tape over the damaged blister. She stated the risk would be a potential for drug diversion and infection control. She stated the nurses were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would waist the pill with another nurse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3- Record review and observation on 04/22/25 at 12:45 PM of Nurses Cart Hall 200, with RN A revealed the blister pack for Resident #62's tramadol 50 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister. Interview on 04/22/25 at 12:50 AM, RN A stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seal was broken. She stated the risk would be a potential for drug diversion. She stated the nurses were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated she would waist the pill with another nurse. Interview on 04/24/25 at 10:02 AM, the DON stated she expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON, and the DON were supposed to check the carts weekly and the pharmacy consultant to do the audit once a month. Record review of the facility's policy titled Storage of Medications, revised April 2007, revealed in part .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen. The facility failed to ensure food item in the facility walk-in freezer were covered. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on 04/22/25 at 09:54 AM of the facility walk-in freezer revealed a packet of Frozen pork and vegetable eggrolls loosely wrapped in a plastic bag which was kept in an open cardboard box. In an interview on 4/23/25 9:56 AM with Corporate Dietitian stated it was her expectation that all food items should be dated, labeled, and covered at all times. She stated the frozen egg rolls were thrown away on 4/22/25 since they were left open in the freezer. She stated if food items are not covered, the risk would be cross contamination of food with possible freezer burn and loss of quality. In an interview on 04/23/25 10:04 AM with the Dietary Manager stated everyone including cooks and herself were responsible for covering, dating, and labeling all food items in the kitchen. She stated her expectation was all food items in the kitchen should be appropriately covered and sealed. She stated the risk of not covering food items was cross could result in freezer burn, contamination resulting in food borne illness. In an interview on 4/24/25 at 11:24 AM with [NAME] E revealed she had been working in the facility for the last 10 months. She stated everyone in the kitchen including cooks, dietary aides, and the dietary manager were responsible for covering food items in the kitchen. She stated not covering food items appropriately could cause food to be spoiled and residents could get sick. Review of facility's policy titled Food Storage undated reflected, .16. Frozen foods . Foods should be covered, labeled, and dated . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

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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** Based on observation, interview, and record review, the facility failed to 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 2 of 21 residents (Resident #1 and Resident #5) observed for infection control. 1. The facility failed to ensure RN A used the required PPE for Resident #1, who was on enhanced barrier precautions due to her indwelling urinary catheter, while changing the indwelling urinary catheter on 04/23/25. 2. The facility failed to ensure CNA K changed her gloves and performed hand hygiene while providing incontinence care to Resident #5 on 04/22/25. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record review of resident #1s quarterly MDS assessment, dated 02/28/25, reflected a [AGE] year-old female with an admission date of 08/01/24. She had a BIMS score of 15 which indicated she was cognitively intact. She was dependent for toileting care. She had a foley catheter and was frequently incontinent of bowel. Active diagnoses included multiple sclerosis (disease that causes breakdown of the protective covering of nerves) and neurogenic bladder (disruption in the nervous systems connection to the bladder). Record review of Resident #1's Physician Order Summary report dated 04/24/25, reflected, Enhanced Barrier precautions every shift Follow Facility Policy-**USE for patients with any of the following (when Contact Precautions do not otherwise apply) Wounds or indwelling medical devices regardless of MDRO (multiple drug resistant organism) colonization(the presence of microorganisms like bacteria where the organisms grow and multiply but do not cause visible disease) status infection or colonization with an MDRO**, with a start date of 01/09/25. Record review of Resident #1's care plan, initiated on 03/20/25, reflected, Enhanced Barrier Precautions implemented related to Urinary catheter .Goal-The spread of MDRO will be reduced over the next 90 days . Interventions .Implement Enhanced Barrier precautions .monitor for signs and symptoms of infection . In an interview and observation on 04/23/25 at 9:50 a.m. Resident #1 was lying in bed with a strong urine odor. Resident #1 stated she thought her catheter was leaking and stated she hated the smell. Signage was posted outside of the Resident's door indicating she was on Enhanced Barrier Precautions. Observed container inside Resident #1's room which contained gowns and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 04/23/25 at 10:30 a.m. RN A entered Resident #1's room with the catheter kit needed to change the suprapubic catheter (catheter that is inserted through the abdominal wall into the bladder). RN A washed her hands and put on utility gloves but did not put on a gown. RN A placed the catheter kit and foley catheter on the bed, put on utility gloves and removed the old catheter. RN A removed her gloves and washed her hands and proceeded with the replacement of the suprapubic catheter. RN A then removed her gloves, disposed of the trash, and performed hygiene. In an interview with RN A on 04/23/25 at 10:45 a.m. she stated Resident #1 was in Enhanced Barrier Precautions due to her indwelling urinary catheter. She stated she should have worn a gown and just overlooked it when she entered the room. She stated the risk of not following Enhanced Barrier Precautions was the spread of MDRO's. In an interview with the DON on 04/23/25 at 02:00 p.m. she stated any resident who had any type of indwelling medical device was placed on Enhanced Barrier precautions to help reduce the spread of MDRO's. She stated signage was posted outside to the door, which explained what PPE was to be worn and for what task the PPE was to be worn for. She stated any contact with a resident with a urinary catheter required the use of gown and gloves. She stated the staff had received numerous trainings on the use of Enhanced Barrier Precautions. Record review of the Facility's policy titled, Enhanced Barrier Precautions, dated August 2022, reflected, Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .EBP employ targeted gown and glove use during high contact resident care activities when contact precautions no not otherwise apply .Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include .device care or use (.urinary catheter .)EBPs remain in place for the duration of the residents stay or until resolution .or discontinuation of the indwelling medical device that places them at increased risk .Staff are trained prior to caring for resident on EBPs .Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required . 2. In an observation on 04/22/25 at 10:29 AM CNA K entered Resident #5's room to provide peri-care. She washed her hands and put on gloves. She uncovered resident and she unfastened the resident brief revealing wet brief. She cleaned the resident's front pubic area with several wipes. CNA K changed her gloves without hand hygiene. She rolled the resident on her side, removed the soiled brief, and wiped the anal area from front to back and then the buttocks, changing to a clean wipe with each swipe. CNA K then pushed the soiled sheet under the resident and with soiled gloves placed a clean brief under the resident. She then rolled the resident over, and she closed the resident brief. Without changing gloves, she assisted resident to sitting position and then to standing position and she transferred her from bed to wheelchair. She changed gloves without hand hygiene and assisted resident to put on clean T-shirt. She removed her gloves, washed her hands, and left the room. In an interview on 04/22/25 at 11:45 AM CNA K stated she was supposed to change her gloves and perform hand hygiene when she went from dirty to clean. CNA K stated she should have sanitized her hand between change of gloves. She stated failing to provide proper care exposed the resident to infections. CNA K stated she did not realize she had soiled gloves on when she put the clean brief under the resident. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/24/25 at 10:02 AM the DON stated they had trained at length on when staff were to change their gloves and sanitize their hands. She stated staff needed to change their gloves when they go from dirty to clean. She stated the risk was increased risk of infections. She stated she and the ADON would be re-training and observing care to ensure staff compliance. Record review of CNA K's competency check off for hand hygiene and infection control revealed she was proficient in care as of 02/28/25. Record Review of the Facility's policy titled, Perineal Care, dated October 2010, reflected, The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition .Wash and dry your hands .put on gloves .For female resident . Wash perineal area, wiping from font to back .Separate labia and wash area downward from front to back. Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes .Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks .Remove gloves .Wash and dry your hands . Record review of the facility's policy titled, Hand Washing, dated August 2012, reflected, .Hand washing is the single most important means of preventing the spread of infection .After Patient contact .Wash hands with soap and running water .May use Hand sanitizing gel in place of soap and water .