STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676370	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmonee House	1400 Main St Amherst, TX 79312

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 46534 Based on interview and record review the facility failed to consider the views of a resident group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility for 3 of 8 anonymous residents. The facility failed to address a grievance put forth by the resident council regarding a resident who sang disruptively loud and spit on the floor and on other residents during meals. This failure could lead to residents feeling unheard and unvalued in their place of residence. Findings Included: During a resident council meeting on 09/10/24 at 10:20 AM 3 of 8 attendees complained about a certain resident who sang at the top of her lungs during meals and spit loogies on the floor and occasionally on other residents during meals. The anonymous residents said the singing made it hard to hold conversations during mealtimes and the loogies made them lose their appetites. The residents stated that during lunch yesterday, when state was observing meal pass, the singing, spitting resident was not brought to the dining room to eat. One of the anonymous residents said she filed a grievance with ADON regarding the singing, spitting resident. The anonymous resident said she was asked to write down her complaints and she did so. She said ADON told her there was nothing the facility could do because it was not fair to the singing, spitting resident to exclude her from the dining room. The anonymous resident then asked if she could take her meals in her room and was told she had to eat at least two meals a day in the dining room. One of the other anonymous residents stated the singing, spitting resident spit a loogie on her forearm during a meal and ruined her appetite. Another of the anonymous residents stated the singing, spitting resident spit on the residents she did not like. All three anonymous residents stated they brought up their concerns last month at the resident council meeting and were told again that there was nothing the facility could do because it would infringe upon the singing, spitting resident's rights to exclude her from the dining room. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the past 6 months of grievances revealed no grievance about the singing, spitting resident. Record review of the past 6 months of resident council minutes revealed no mention of the singing, spitting resident. The resident council meeting minutes from last month revealed all three anonymous residents were in attendance at the meeting on 08/27/24 and ADON was the staff in attendance. During an interview on 09/11/24 at 09:44 AM LVN B stated when a resident told her they wanted to file a grievance she took it to the DON. She said if a resident filed a grievance and it was ignored, I'm sure they would kind of be upset about it. She stated she saw the singing, spitting resident being loud and disruptive in the dining room almost every day. LVN B stated she saw the singing, spitting resident spit on her chair, the floor, kind of anywhere. She stated she has not seen the singing, spitting resident spit on another resident. When asked what kind of interventions were tried when the singing, spitting resident was disruptive in the dining room and other residents complained she said nursing staff would try to redirect the singing, spitting resident or move her to another table. During an interview on 09/11/24 at 09:56 AM CNA E stated if a resident wanted to file a grievance, she would alert her charge nurse. She stated if a resident filed a grievance, and it was ignored the resident would be negatively impacted because they have that right. She stated she has seen the singing, spitting resident yelling and singing in the dining room a lot. She said, At least they are church songs. She is very, very loud. CNA E stated she had not seen the singing, spitting resident spit on another resident but she had seen her spit on the floor. She stated, She just did it for breakfast. During an interview on 09/11/24 at 10:03 AM ADM stated when a resident wants to file a grievance the facility will formalize it through written grievance process and follow up. She stated, We talk about it as a team and work to resolve issues promptly. She stated the facility does not have a particular staff who is the grievance officer but that all executive staff work together to resolve grievances. ADM stated to have a grievance ignored would have a negative impact on a resident. She said she had seen the singing, spitting resident being disruptively loud in the dining room. ADM stated she had seen the singing, spitting resident spit on the floor one time and had never see her spit on another resident. During an interview on 09/11/24 at 10:33 AM ADON stated when a resident filed a grievance, she would put it in the grievance book and follow up on it and try to resolve it. She stated she did not remember the anonymous resident writing up a grievance regarding the singing, spitting resident and she did not remember the residents in resident council complaining about the singing, spitting resident during last month's meeting. She stated residents are not told they have to eat at least two meals in the dining room. She said they are encouraged to do so, but it is not a rule. When asked if she had witnessed the singing, spitting resident being disruptive in the dining room she stated, Um, at least daily! We give her coffee to redirect her. ADON said of the singing, spitting resident, She has a bad habit of spitting. Sometimes we move her to a table around the nurses' station and it calms her. She spits from frustration or overstimulation. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/11/24 at 11:42 AM DON stated when a resident comes to her and tells her they do not like something or are unhappy she files a grievance on their behalf and assigns it to herself to ADON to investigate and resolve. DON said there was absolutely a negative outcome if a resident filed a grievance, and it was ignored. She continued, I mean, I don't get grievances from the ones that have dementia, so the ones that do have a grievance are cognitively aware and expect me to find a solution or at least be willing to come to an agreement. DON stated there is not rule that residents must eat in the dining room twice a day though she did say it was encouraged. She stated she has witnessed the singing, spitting resident being disruptive in the dining room. She said when she hears the singing, spitting resident being loud she gives her a cup of coffee. DON stated she had not seen the singing, spitting resident spit on another resident but added, I have seen her spit on the floor. I have known her all my life and it is her nature. When I see her do it, I hand her a paper towel ask her to spit in the paper towel. Record review of facility policy titled Resident Rights and dated December 2020 revealed in part: . Federal and state law guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . u. voice grievances to the facility . v. have the facility respond to his or her grievances . Record review of facility policy titled Grievances/Complaints, Recording and Investigating and dated August 2024 revealed in part: All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve grievance(s). 2. Upon receiving a grievance and complaint report the grievance officer will begin an investigation into the allegations. 7. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to immediately inform the resident; consult with the resident's physician; and notify consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status and notify the resident and the resident representative, if any, when there is a change in room for 1 (Resident #6) of 12 residents reviewed for notification of change of condition. The facility failed to inform Resident #6's family of his positive COVID test and subsequent change of rooms to an isolation room. This failure could place residents at risk of not having their change in condition communicated to their physician or representative. Findings Included: Record review of Resident #6's admission record dated 09/10/24 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, acute bronchitis (lining of tube that carries air to and from the lungs is inflamed causing cough with mucus, shortness of breath, and mild fever), dementia (a group of thinking and social symptoms that interferes with daily functioning), heart disease, and chronic obstructive pulmonary disease (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue). Resident #6's family member A was listed as his responsible party and #1 emergency contact with two phone numbers and an address. His family member B was listed with one phone number and an address. Record review of Resident #6's significant change MDS completed 05/11/24 revealed the following: Section C indicated a BIMS score of 3 which indicated severely impaired cognition. Section F indicated it was very important to Resident #6 to have his family involved in discussions about his care. Record review of Resident #6's care plan initiated on 08/05/24 revealed entry dated 09/09/24 which indicated Resident #6 was positive for COVID and was moved into an isolation room. Record review of Resident #6's progress notes from 09/09/24 revealed the following: On 09/09/24 at 03:10 PM LVN A noted Resident still not feeling well this afternoon and continues with increased sleepiness and weakness. Also noted with nasal congestion. [Name of hospice nurse] with [Name of hospice] notified, and telephone order received to test resident for Covid. Resident tested for Covid using rapid test and results were positive. Resident placed on isolation precautions and [Name of hospice nurse] hospice notified. Awaiting any further orders at this time. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/24 at 11:23 PM LVN H noted At approx. 2145 (09:45 PM) writer entered room just as resident slid out of bed onto his bottom. Called for assistance with call light. (Resident was) Oriented to self only. Unable to state why he was trying to get out of bed. Denies pain on assessment. Active ROM x 4 extremities, no deformities noted. Assisted to standing position and then back to bed. Incontinent care provided and settled back into bed. Fluids and call light are in reach. Called to notify [Name of Resident #6's family member A], [Name of Resident #6's family member B] answered and stated she would let [Resident #6's family member B] know. Resident #6's progress notes from 09/09/24 to 09/10/24 revealed no documentation of notification of family regarding his positive COVID test and subsequent room change. During an observation on 09/09/24 at 12:02 PM Resident #6 was lying on his back in bed under a blanket with his bed flat. He had his eyes closed and the lights in his shared room were off. During an interview on 09/09/24 at 03:23 PM Resident #6's family member A was asked if the facility had notified her or Resident #6's positive COVID test. She replied the facility had called her in the past to let her know COVID was in the building but Resident #6 was okay. She indicated she had not received a call about his recent positive COVID test. During an interview on 09/10/24 at 08:09 AM Resident #6's family member B answered family member A's phone and stated the family had not been notified of Resident #6's positive COVID test and subsequent room change. She stated on 09/09/24 the facility did call to notify the family of a fall Resident #6 had where he slid out of his bed but was not injured. She stated during that call the facility said nothing about a positive COVID test or room change. Resident #6's family member asked how long he would be on isolation and this surveyor encouraged her to call the facility for more information. During an observation and interview on 09/10/24 at 09:28 AM Resident #6's new room has the door shut with signage on what PPE to wear before entering and to dispose of PPE inside the room. Resident #6 was seated on the edge of his bed in his isolation room. He stated he has started to feel better. During an interview on 09/11/24 at 09:44 AM LVN B stated if a resident had a change of condition the doctor, DON, and family and hospice if they are on hospice should have been notified. She stated family should have been notified if a resident changed rooms. She stated it was the responsibility of the charge nurse to make said notifications and document them in the progress notes. When asked if there would be a negative outcome if a family was not informed of their resident testing positive for COVID she stated, I guess it depends. Especially if family comes often and resident wonders why not seeing them (family). She stated if a resident was positive for COVID, You always want to tell them (family of resident and resident) they are being isolated and the reason. During an interview on 09/11/24 at 09:56 AM CNA E stated if a family was not notified of their resident's positive COVID test it would put others in danger from spread of COVID if the family came to visit their resident. During an interview on 09/11/24 at 10:06 AM ADM stated the physician, family, DON/ADM should have been notified when a resident had a change of condition. She stated family should have been notified when a resident changed rooms. She stated nursing was responsible for making said notifications. She stated there was a negative outcome for residents if the family was not notified of positive COVID and a room change but she did not elaborate on what the negative outcome was. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/11/24 at 10:33 AM ADON stated immediate family should have been notified when a resident had a change of condition or change of room. She stated she thought LVN A notified the family of Resident #6 of his positive COVID test. ADON proceeded to look through Resident #6's progress notes in the EHR and said, But he (LVN A) didn't chart it. She stated there was no other place LVN A would have charted but in the progress notes. She stated charge nurses were responsible for notifying family members when a resident tested positive for COVID and/or had a change of room and they were to document the notification in the progress notes. She stated a possible negative outcome of not notifying family of positive COVID test and room change was the family would be shocked when they came to visit their family member. During an interview on 09/11/24 at 11:42 AM DON stated charge nurses were responsible to notify physician and family when a resident had a change of condition or rooms. She stated the notification should be documented in the progress notes. When asked what a negative outcome of not notifying a family would be, DON stated, It depends, if the resident has dementia, they won't know one way or the other. It is situational to me. Some families don't participate in care, but still need to be notified. During an interview on 09/11/24 at 12:05 PM LVN A stated he did call Resident #6's family member A to notify her of Resident #6's positive COVID test and resultant room change. He stated, She was having a hard time following what he was saying. He stated he did not know why he did not document the notification. Record review of facility policy titled Change in a Resident's Condition or Status and dated July 2024 revealed in part: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status . 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: . b. There is a significant change in the resident's physical, mental, or psychosocial status; c. There is a need to change the resident's room assignment; .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview and record review the facility failed to ensure the care plan is prepared by an interdisciplinary team, that includes to the extent practicable, the participation of the resident and the resident's representative(s) and if the participation of the resident or their resident representative is determined not practicable for the development of the resident care plan include an explanation in the resident's medical record for 1 (Resident #6) of 12 residents reviewed for care plan timing and revision. The facility failed to invite Resident #6's family members to his care plan meeting. This failure could lead to a lack of cohesiveness in resident care and/or residents not receiving necessary care. Findings Included: Record review of Resident #6's admission record dated 09/10/24 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, acute bronchitis (lining of tube that carries air to and from the lungs is inflamed causing cough with mucus, shortness of breath, and mild fever), type 2 diabetes (insufficient production of insulin, causing high blood sugar), dementia (a group of thinking and social symptoms that interferes with daily functioning), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), heart disease, cerebral aneurysm nonruptured (bulge or ballooning of blood vessel in the brain), and chronic obstructive pulmonary disease (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue). Resident #6's family member A was listed as his responsible party and #1 emergency contact with two phone numbers and an address. His family member B was listed with one phone number and an address. Record review of Resident #6's significant change MDS completed 05/11/24 revealed the following: Section B indicated Resident #6 had unclear speech and was sometimes understood, but he usually understood others. Section C indicated Resident #6 had a BIMS score of 3 which indicated severely impaired cognition. Section F indicated it was very important to Resident #6 to have his family involved in discussions about his care. Record review of Resident #6's care plan initiated on 08/05/24 revealed he would not be discharged to the community due to advanced dementia. The care plan indicated Resident #6 had impaired cognitive function, impaired thought processes, and difficulty making decisions due to long and short-term memory loss as well as difficulty communicating. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/09/24 at 03:31 PM Resident #6's family member A stated she had not been invited to participate in a care plan for Resident #6 during his time in the facility. She said, They send me a letter when there is a party or something like Easter or Father's Day. During an interview on 09/10/24 at 03:38 PM ADM stated DON was responsible for inviting family members to care planning meetings. She said DON sent a letter to the family and if she did not hear back from the family she would call them to determine if they wanted to attend the meeting or not. During an interview on 09/11/24 at 09:24 AM DON stated she did not think she had any proof of inviting Resident #6's family to the care plan meeting. She stated it was in August and Resident #6's family member A came to talk with her. DON stated she was not sure of the day, just that it was in August. During an interview on 09/11/24 at 09:26 AM DON stated Resident #6's family member A has been diagnosed with dementia and is close to being admitted to the facility so would probably not remember speaking with her (DON) about Resident #6's care plan. She stated she thought she wrote on the care plan itself that Resident #6's family member was a part of the meeting, but she would check to be sure. During an interview on 09/11/24 at 09:44 AM LVN B was asked for a negative outcome for residents if family members were not invited to the care plan. She did not answer the question but she said, They (family members) should be invited, I know they are always invited. During an interview on 09/11/24 at 09:56 AM CNA E stated a family's invitation to resident care plans was important to keep the family involved in what is going on. She stated, These residents here change regularly. There are a lot of memory issues and they (family) need to be up to date on what is going on. During an interview on 09/11/24 at 10:06 AM ADM stated a possible negative outcome of family members of residents not being invited to care plans was, They would not be involved in care (of residents) and they are a vital part of care (of residents). During an interview on 09/11/24 at 10:33 AM ADON stated DON is responsible for inviting residents' family members to care plan meetings. She said a possible negative outcome of family members not being invited to care plans meetings was the family would not be up to date on their (residents) care. During an observation and interview on 09/11/24 at 11:42 AM DON stated she could not prove she invited Resident #6's family to his care plan. She stated, I am gonna say I dropped the ball. I did have a visit with her (Resident #6's family member A) in August . but I can't prove that I did. She held up an invitation letter to a care plan for another resident and stated she could not find the copy of the one she mailed to Resident #6's family member. She said when she invited family members to care plans, she mailed the letter and kept a copy for herself, but she could not find a copy of one for Resident #6's care plan in August. She said a possible negative outcome of a family not being invited to be part of the care plan meeting was, I mean it just helps them feel more involved in their loved one's care and they need to know what is going on with their loved one, any decline, any medication change. Record review of facility policy titled Care Planning-Interdisciplinary Team and dated September 2013 revealed in part: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. 3. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 4. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. Record review of facility policy titled Resident Rights and dated December 2020 revealed in part: . 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . p. be informed of, and participate in, his or her care planning and treatment; .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observations, interviews, and record reviews the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 5 of 8 anonymous residents observed for 3 of 3 (September 9, 10, and 11 of 2024) days and reviewed for quality of life. The facility failed to ensure scheduled activities were taking place. The facility failed to ensure activities met resident's needs/desires. These failures could place residents at risk of boredom and/or a decline in their quality of life. Findings Included: Record review of facility activities calendar dated September 2024 revealed at least 5 activities scheduled each weekday and two activities scheduled each Saturday and Sunday for the month. In total there were 125 activities listed. Of those 65 were passive TV-based to include watching Wheel of Fortune (21 times), The Price is Right (19 times), Movie Madness (4 times), a chair-based exercise program called Sit and Fit (8 times), football games (9 times) and something listed as Days to Remember (4 times). Of the remaining 60 activities 32 were independent or required minimal social interaction to include Bird Watching (5 times), Independent Activities (4 times), One-on-One Visits (4 times), Music We Remember (5 times), Beauty Shop (2 times), Coffee & Chat (9 times), and Coloring (3 times). Of the remaining 28 activities 10 were led by volunteers from outside the facility to include Church (5 times), Bible & Bingo (4 times) and Pep Rally (1 time). The remaining 18 activities included Manicures and Chit Chat (4 times), Dominoes (4 times), Resident Council (1 time), Ice Cream Social (3 times), Monthly Birthday Party (1 time), National Donut Day (1 time), and Bingo (4 times). The calendar revealed the following times and activities scheduled for the three days of observation: 09/09/24: 9:00 Coffee & Chat; 10:00 Bird Watching; 11:00 Price is Right; 2:00 Music We Remember; 6:30 Wheel of Fortune 09/10/24: 9:00 Manicures and Chit Chat; 10:00 Sit & Fit; 11:00 Resident Council; 2:00 Movie Madness; 6:30 Wheel of Fortune 09/11/24: 9:00 Dominoes; 10:00 Bible and Bingo; 11:00 Price is Right; 2:00 Days to Remember; 630: Wheel of Fortune During an interview on 09/09/24 at 11:25 AM DON stated ADON is also the AD, one of the infection preventionists, and the MDS nurse. (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/09/24 at 11:50 AM The Price is Right was playing on the TV in the dining room as residents were sitting at various tables talking with one another and waiting on lunch service. Few residents were seated facing the TV and those that were facing the TV were not looking at the TV. During an interview on 09/09/24 at 04:14 PM an anonymous resident stated the only activity provided was Bingo on Wednesdays and he enjoyed attending. During an interview on 09/10/24 at 10:20 AM 5 of 8 anonymous residents stated the facility only had activities on Wednesday. They stated the activity was bingo and bible study. When asked what types of activities they would like they stated, movie nights and crafts or something. The residents also mentioned that some residents could not use their hands or really understand games and might like to have music played for them. During an observation on 09/10/24 at 02:42 PM revealed no one in the sitting area in the lobby and the TV was off. During an observation on 09/10/24 at 02:43 PM two residents were noted to be watching a TV commercial at the end of the hall in the common area and one resident was noted to be watching TV in the dining room. No staff were present in either locale. During an interview on 09/10/24 at 02:44 PM LVN A stated Movie Madness as listed on the activities calendar across from the nurses' station to be taking place today beginning at 02:00 PM usually takes place at the end of the hall or in the lobby area. He stated the TV hanging in the dining room had not been hanging there very long and he had not seen Movie Madness take place in the dining room. During an observation and interview on 09/10/24 at 02:48 PM two anonymous residents were in a resident room watching TV. On the wall was a copy of the activities calendar. The residents stated the activities on the calendar do not happen. They stated the only reason Bingo and Bible Study took place was because a volunteer from a nearby town came in and hosted the activity. They stated they did not know ADON was AD until today's resident council meeting. During an observation on 09/11/24 at 09:31 AM three residents were seated at three different tables in the dining room. There were no dominoes visible. During an observation on 09/11/24 at 09:31 AM two residents were seated in the common area at the end of the hall. One on the couch and one in a w/c. They were not facing one another, and no dominoes were visible. During an observation on 09/11/24 at 09:32 AM the two tables in the lobby area had no residents seated around them and no dominoes were visible. During an observation on 09/11/24 at 09:33 AM the activity room was empty but cheerful and full of colorful paintings, puzzles, etc. No dominoes were visible. During an interview on 09/11/24 at 09:38 AM HSK F stated she had worked for the facility for 2-3 months and had not observed residents involved in activities 4-5 times a day on weekdays. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/11/24 at 09:38 AM HSK G stated she had worked for the facility for 1 month and had not observed activities taking place 4-5 times a day on weekdays. During an observation and interview on 09/11/24 at 09:44 AM LVN B stated she had noticed residents involved in activities 4-5 times each weekday. When asked for an example she replied, Bingo and bible on Wednesdays for a little bit, sometimes watch TV, coffee time. She stated the CNAs lead activities but added, We have a helper that comes on Wednesdays. When asked if the residents played dominoes this morning she said, They are about to start right now, they are going to do bible and play bingo right now. When asked how residents know when an activity is taking place, she gestured to the board across from the nurses' station and said, Usually it is posed on that board right there and of course we remind them like today is Wednesday Bingo day. When asked where the activity Bird Watching took place she gestured to the window in the dining room from which you could see several bird feeders. When asked if staff are part of the bird watching activity she stated, Usually they (residents) will just sit there and watch them (birds). LVN B stated there was not a negative outcome for residents if the activities calendar was not followed. During an interview on 09/11/24 at 09:56 AM CNA E stated she had worked for the facility for 7 months and she had observed residents involved in activities. When asked what kind of activities she stated, In summer they went outside a lot, had watermelon and ice cream on the patio. She stated the residents were going to play bingo today because a former resident's family member still comes and leads bingo. CNA E stated she had never helped organize or lead activities. She stated the residents do not have enough activity involvement. She said, I think if they had more there would be less .I'm not saying there's a lot of falls, but we have to redirect a lot of people (residents) because they wander a lot. During an interview on 09/11/24 at 10:06 AM ADM stated she sees the resident involved in activities 5-6 times each weekday. She said, Our activities are a little less structured here and have a difficult time getting resident involvement. Dominoes was a thing for awhile and then it became this huge fight. When asked who usually led the activities she stated CNAs, ADON, and volunteers. She stated the facility is looking for a full time AD. When asked if there was a negative to outcome for residents if the activities calendar was not followed, ADM said, Yes, just that they anticipate something that didn't occur. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/11/24 at 10:33 AM ADON stated the CNAs lead the activities on the weekdays. She stated her family member was a day CNA and was in charge of activities, but the family member transitioned to nights at the beginning of September. ADON stated her family member did not have AD certification. She stated Movie Madness on the activities calendar was when the CNAs basically set up a movie in the dining room and a movie in the other TV area at the end of the hall. She said sometimes a third movie would be playing in the lobby area. She stated it was called madness because movies were playing everywhere. She stated Movie Madness activity was held on 09/10/24 in the dining room and in the common area at the end of the hall. When asked who hosted Manicures and Chit Chat yesterday, ADON said she did not know. When asked who hosted Sit and Fit yesterday, she stated, I thought they turned on the TV yesterday morning but, honestly, I did not follow up yesterday. She stated residents are aware of activities because we go through and ask verbally if they want to attend. When asked what types of activities are done for residents who are bedbound or unable to participate in bingo, ADON stated, Usually our bedbound have hospice visitors coming in. The hospice marketer comes in and chaplains come in. She stated of the residents in the facility, We have maybe 5 who are totally with it. Sometimes we just play music and dance in the hallways. ADON stated weekend activities are led by CNAs and local churches. When asked what Independent Activities meant she said the residents could put puzzles together, read, or have family visits. ADON stated residents were allowed to be in the Activities Room when there was a craft. When asked what Days to Remember on the activities calendar was ADON said, Like today, we played a 9/11 video this morning at breakfast and will print out things for them to color. She said Music We Remember on the activities calendar involved staff playing music from the 50s and 60s on YouTube or the [NAME] at the nurses' station. When asked if it felt doable for her to be ADON, AD and MDS nurse, she stated, Spread thin most days because then I help with housekeeping too. ADON stated she felt the residents had enough activities to meet their needs. She could not think of a negative outcome of not following the activities calendar. During an interview on 09/11/24 at 11:42 AM DON stated she had not seen residents involved in activities 5-6 times a day as noted on the activities calendar. She stated activities were led by CNAs. When asked if she thought residents had enough activities to meet their needs she stated, No, I don't think they do. One thing is they don't eat as well, don't get enough exercise to burn calories so don't get hungry. They don't receive the socialization that I feel like they probably need. When asked if there was a negative outcome for residents if the activities calendar was not followed, DON stated, Yeah, I mean they expect those things to take place. Record review of resident council minutes dated 06/06/24 revealed ADON's family member was staff person in attendance and the note regarding activities was, Wish we could do more activities with you instead of you being on the floor as a CNA. Record review of facility policy titled Activity Programs - Staffing and dated June 2018 revealed in part: Our activity programs are staffed with personnel who have appropriate training and experience to meet the needs and interests of each resident. 2. The activity director/coordinator's responsibilities include: . c. monitoring and evaluating the residents' responses to activities and revising the approaches as appropriate; and d. developing, implementing, supervising and evaluating the activity programs at least quarterly. 5. Sufficient activity personnel are on duty to meet the needs of the residents and the functions of the activity programs.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48221 Based on observation, interview, and record review; it was determined the facility failed to ensure medications were stored and labeled in accordance with currently accepted professional principles on 1 of 1 medication carts, in that:. 3 medications were left loose in the medication cart and 2 residents' insulin vials and box packaging were not marked correctly with date of opening. 1 insulin medication vial in the medication cart drawer one was marked with an open date of [DATE] and the box packaging was dated [DATE]. Insulin was still in use after 55 days from documented vial opening date. 1 insulin medication vial in the medication cart drawer one was open without an opening date marked on the vial or box packaging. The facility's failure to ensure medications were labeled in accordance with currently accepted professional principles could place residents at risk for exposure to medication that is expired or ineffective; resulting in exacerbation of the disease being treated, exposure to contaminated products capable of causing infection, and other adverse reactions. Findings include: During observation on [DATE] at 11:32AM the medication cart was observed with Facility LVN A. In drawer one there was an open multidose vial of Novolog Insulin. Vial was dated [DATE] and box packaging dated [DATE]was still in use 55 days after having been opened. LVN A verified the date written on the vial was [DATE] and the date on the box packaging was [DATE]. LVN A was asked how many days from open date is insulin discarded. He stated,30 days from the opening date. During observation on [DATE] at 11:36 AM to the medication cart drawer one an open vial of Lantus Insulin was observed without an open date on the vial or the box packaging. LVN A was asked when is the opening date to be documented on the insulin vial. He stated, When it is opened. LVN A verified there was no date documented on the insulin vial or box packaging. During observation on [DATE] at 11:40AM medication cart second drawer had 3 loose medications. LVN A was able to identify the 3 loose medications. LVN A identified the medications. LVN A was asked what could be potential negative outcomes from residents not receiving these medications. He stated, Missing the Bethanechol could cause bladder discomfort, the Lasix could cause edema and the Eliquis could cause blood clots. Interview with Administrator on [DATE] at 2:15PM she was asked for a policy on Medication Cart Monitoring and Medication Administration. She started the night shift nurse usually cleans, monitors, and stocks the medication cart. She did not know about the policies but would find them if she could she stated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview [DATE] at 10:19AM with the DON when asked about who is responsible for monitoring the medication cart she stated, The Charge Nurse is responsible to clean it once a week. Usually, the night nurse and the Chare Nurse have that responsibility. The medication cart is everybody's responsibility. She stated, The policy for the medication Insulin is to be dated on the vial when it is opened and discarded after 30 days. When asked about the loose pills in the medication cart the DON stated, I feel we are doing much better with the prepackaged medications. We are finding less loose pills than we use to. When asked about the possible negative outcome of administering outdated medications to residents she stated, That's why we have expiration dates on medications so we will know. Negative outcomes for a resident could be uncontrolled blood glucose, hyperglycemia, or hypoglycemia. Interview on [DATE] at 10:35AM with the ADON. She stated there is no policy for Medication Cart Monitoring. She stated, Usually the night nurse manages the medication cart cleaning and stocking. If we have an agency nurse over the weekend I go through the cart on Mondays. Asked about policy on medication insulin opening and discarding she stated, Insulin is to be dated on the day of opening of it. It is discarded 30 days from that opening date. Record review of facility policy revealed the following: Policy Title: Storage of Medications Date issued: MED-PASS, Inc. [DATE] 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed 12. Only persons authorized to prepare and administer medications have access to locked medications. On [DATE] at 2:15PM asked Administrator for Medication Administration Policy. Did not receive prior to facility exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure freezer items were properly stored, labeled, and dated. 2. The facility failed to ensure pantry foods were properly stored, labeled, and dated. 3. The facility failed to ensure refrigerated foods were properly stored, labeled, and dated. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings included: Observation of the refrigerator on [DATE] at 11:12 AM revealed the following: 1. (1) bottle of ketchup, no date. 2. (2) trays of cups, filled with various liquids, covered by a tray, no labels, or dates. Observation of walk-in pantry on [DATE] at 11:15 AM revealed the following: 1. (1) box of potatoes, open to the air, no label or date. 2. (1) package of hot dog buns, 2 buns left, no label or date. 3. (5) individual applesauce cups, no dates. 4. (1) loaf of bread, no date. Observation of walk-in freezer on [DATE] at 11:20 AM revealed the following: 1. (6) Styrofoam cups with lids, filled with what appeared to be fruit, no labels, or dates. 2. (2) bags of frozen veggies, no label or date. 3. (1) box of what appeared to be breaded meat, no label or date. In an interview on [DATE] at 10:35 AM, [NAME] C stated that all the cooks are responsible for labeling and dating food. He stated that if they put food out that was expired or bad, then someone could get sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 10:39 AM, DM stated that it was everyone's responsibility in the kitchen to label and date food as it comes in and they must label and date leftovers. DM stated that she trains her staff by doing in services on labeling and dating foods as well as making sure leftovers are labeled. She stated that a negative outcome for not doing this could be that they could serve expired food to residents, and it could make them sick. In an interview on [DATE] at 10:45 AM, [NAME] D stated that it was everyone's responsibility to check that food was labeled and dated properly. She stated that a possible negative outcome of food not being labeled and dated was they could serve spoiled food and it could make the resident's sick. Record Review of facility policy dated [DATE] titled Food Receiving and Storage revealed in part: .7. Dry foods that are stored in bins will be removed from original packaging, labeled and dated . .8. All foods stored in the refrigerator or freezer will be covered, labeled and dated.