STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - New Br	2468 Fm 1101 New Braunfels, TX 78130

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 27520

Based on observation, interview and record review the facility failed to ensure the assessment accurately reflect the resident's status for 2 of 8 Residents (Resident #76 and Resident #85) whose records were reviewed.

1. Nursing staff failed to code that Resident #76 was diagnosed with Depression on his annual assessment, dated 2/2/25.

2. Nursing staff failed to code that Resident #85 received oxygen therapy on her annual assessment, dated 2/4/25.

This deficient practice could affect any resident and contribute to residents not receiving care and services as needed.

The findings were:

1. Review of Resident #76's face sheet, dated 3/28/25, revealed he was admitted to the facility on [DATE] with a primary diagnosis of Encounter for surgical aftercare following surgery on the digestive system.

Review of Resident #76's Psychiatric Initial Assessment, dated 2/6/25 revealed he was diagnosed of adjustment disorder with depressed mood (According to Mayo clinic it refers to symptoms of depression that occur for a short time and after facing a significant stressor that has overwhelmed ability to cope).

Review of Resident #76's MDS assessment, dated 2/23/25, revealed there was no indication Resident #76 had a diagnosis of Depression.

Interview on 03/26/25 at 11:00 AM with Resident #76's family member revealed Resident #76 was in therapy. She stated Resident #76 had a G-tube placement most recently and reported Resident #76 was adjusting to not having food. She stated Resident #76 was a little depressed.

Interview on 03/27/25 at 04:02 PM with MDS Coordinator/LVN G revealed Resident #76's MDS assessment did not capture he had been diagnosed with Depression. She stated it was important to accurately reflect Resident #76's status so staff would provide the necessary care and services needed.

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #85's face sheet, dated 3/27/25, revealed she was admitted to the facility on [DATE], with diagnosis including Chronic Obstructive Pulmonary with acute exacerbation. Review of Resident 85's physician orders for March 2025 revealed an order: O2 AT 2-4L/MIN CONTINUOUS PER NC every shift active 1/31/2025 22:00. Review of Resident 85's annual MDS assessment, dated 2/4/25, revealed there was no indication she was receiving oxygen. Review of Resident #85's Care Plan, revised on 2/13/25, revealed she was using oxygen related to respiratory illness. Observation and interview on 03/26/25 at 10:59 AM revealed Resident #85 lying in bed with oxygen infusing via nasal cannula. Resident #85's family member stated he saw staff coming in periodically to check on the concentrator. Interview on 03/27/25 at 03:56 PM with MDS Coordinator/LVN G revealed Resident #85's annual MDS did not indicate Resident #85 received oxygen. She stated it was important to accurately reflect Resident #85's status so staff would provide the necessary care and services needed. Review of a facility policy, Resident Assessment, reviewed on 3/2023, read It is the policy of this facility to ensure that the assessment accurately reflect the resident's status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 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 timeframe's to meet a resident's medical and nursing needs for 2 of 8 Residents (Resident #85 and #92) whose records were reviewed. 1. Nursing staff failed to include Resident #85 used side rails for repositioning and mobility on the comprehensive Care Plan, dated 2/4/25 2. Nursing staff failed to include Resident #92 used side rails for repositioning and mobility on the comprehensive Care Plan, dated 2/24/25. This deficient practice could affect any resident and result in resident's not receiving care and services as needed. The findings were: 1. Review of Resident #85's face sheet, dated 3/27/25, reviewed she was admitted to the facility on [DATE] with diagnoses including Chronic Respiratory Failure with Hypercapnia (according to Mayo clinic, Respiratory failure is a condition where you don ' t have enough oxygen in the tissues in your body (hypoxia) or when you have too much carbon dioxide in your blood (hypercapnia). and Chronic Pulmonary Edema (according to Mayo clinic, condition caused by too much fluid in the lungs). Review of Resident #85's consolidated physician orders for March 2025 revealed an order, MAY USE 1/4 BILATERAL MOBILITY BARS TO AIDE IN EASY TURNING & REPOSITIONING WHILE IN BED. Review of Resident #85's admission MDS, dated [DATE], revealed Resident's BIMS score was 15 of 15 indicating no cognitive impairment. Review of Resident #85's Care Plan initiated on 2/4/25, revealed there was no indication she used side rails for repositioning and mobility. Observation on 03/26/25 at 10:59 AM revealed Resident #85 lying in bed with 1/4 side rails up on each side of the bed. Interview on 03/27/25 at 03:53 PM with MDS Coordinator/LVN G revealed the use of side rails should be reflected in Resident #85's Care Plan so staff would be aware that she used them. It would also ensure nursing staff monitored for any risks involved. She stated Resident #85's Care Plan did not reflect the use of side rails and it could result in staff not monitoring the risks involved and it could further result in an accident or injury. 2. Review of Resident #92's face sheet, dated 3/28/25, revealed he was admitted to the facility on [DATE], with diagnoses including Encounter for Orthopedic aftercare following surgical amputation and acquired of left leg above the knee. (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 - Few	Review of Resident #92's consolidated physician orders for March 2025 revealed and order for the use of 2 1/4 side rails for repositioning and mobility. Review of Resident #92's admission MDS assessment, dated 2/23/25 revealed his BIMS score was 15 of 15 reflective of no cognitive impairment. Review of Resident #92's Care Plan, initiated 2/24/25, revealed no indication Resident #92 used side rails for mobility and repositioning. Observation on 03/25/25 at 11:08 AM Resident #92 lying in bed to the left side with 1/4 side rails up on both sides of the bed. Observation and interview on 03/25/25 at 12:25 PM revealed Resident #92 sitting in a wheelchair eating his lunch meal. He stated he was doing ok but felt cooped up. He stated life changed since his amputation and reported using the side rails for bed mobility. Interview on 03/28/25 at 04:45 PM with MDS Coordinator/LVN G revealed the MDS would reflect the use of side rails if they met the criteria of a restraint. She further stated the use of side rails should be reflected in his Care Plan so staff would be aware that he used them. It would also ensure nursing staff monitored for any risks involved. She stated Resident #92's Care Plan did not reflect the use of side rails and it could result in staff not monitoring the risks involved and it could further result in an accident or injury. Review of facility policy, Comprehensive Person-Centered Care Planning, reviewed 2/2025, read It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review revealed based on a resident's comprehensive assessment, the facility must ensure that a resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 8 Residents (Resident #95) whose records were reviewed for weight loss. Nursing staff failed to follow physician orders to weigh Resident #95 weekly for four weeks and then failed to implement dietary interventions once his weight started trending down. This deficient practice could affect residents at risk for losing weight and result in unplanned weight loss and a decline in the resident's overall health. The findings were: Review of Resident #95's face sheet, dated 3/28/25, revealed he was admitted to the facility on [DATE] with diagnoses including Encephalopathy (according to Mayo Clinic, is a general term describing a disease that affects the function or structure of your brain), Respiratory Failure and Sepsis (according to Mayo clinic, is a serious condition in which the body responds improperly to an infection). Review of Resident #95's Nutrition/Hydration Risk Evaluation, dated 2/1825, revealed his score was 19 placing him at risk. Further review revealed the evaluation read XII. Directive: If the Total Score is 10 or Greater, a prevention protocol should be initiated immediately and documented in the Care Plan. It was signed by LVN B. Review of Resident #95's admission MDS assessment, dated 2/19/25, revealed his BIMS score was 8 reflective of moderate cognitive impairment and he required touching assistance or supervision during eating. Review of Resident #95's Care Plan, revised on 2/20/25, read :Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss and provide, serve diet as ordered. Monitor intake and record q meal; date Initiated: 02/17/2025. Review of Resident #95's progress notes from admission, 2/26/25 through 3/27/25, the nutrition section read: Taking nutrition and hydration orally. No complaints of thirst. No signs / symptoms of a swallowing disorder. Mucous membranes moist. Res was admitted with diagnosis of sepsis was alert but confused for first 2 to 3 days. Review of Resident #95's exact meal intake from 2/27/25 to 3/27/25 revealed his intake varied from 60 to 100%. Review of Resident #95's weights revealed Resident #95 weighed 129.58 on 2/15/25 and 124.9 on 3/1/25. He lost 3.61 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders for March 2025 revealed an order for Mirtazapine (Remeron) Oral Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for poor PO intake Phone Active 02/19/2025 and an order REGULAR diet, MECHANICAL SOFT texture, THIN LIQUIDS consistency Active 3/3/2025. Observation and interview on 03/25/25 at 10:00 AM revealed Resident #95 was lying in bed. He stated he been in the facility for about 45 days, was anxious to return home but want to make sure was ready because he did not want to come back. He stated while at home he collapsed a couple of time and had lost a lot of weight. He stated when he arrived he was delirious and very weak. Observation and interview on 03/27/25 at 03:00 PM revealed Resident #95 sitting in a wheelchair. He stated he was weighed once and he remembered weighing about 120 pounds which was very low for him. He stated he usually weighed between 145 and 150 lbs. Interview on 03/28/25 at 11:00 AM with CNA H revealed Resident #95 required minimal assistance with most ADL's including eating. She stated Resident #95 did not always have a good appetite. She stated this morning he ate about 50% of his breakfast and yesterday he ate 100 % of his lunch. She stated protocol required her to let the nurse know when a resident ate 50% or less of their meal. CNA H stated she had not said anything to the nurse yet. She stated breakfast was usually over by 8:30 AM but had not had the opportunity to tell the nurse. Interview on 03/28/25 at 11:05 AM with LVN B revealed protocol required staff to weigh all new admissions every 7 days for the first 4 weeks. He stated upon reviewing Resident #95's weights, it looked like he was last weighed on 3/1/25 and his weight was trending down. He stated upon reviewing Resident #95's EMAR, it appeared the order for weekly weights did not transfer from the February 2025 to the March 2025 EMAR. LVN B stated this was probably why Resident #95 was not weighed after 3/1/25. LVN B stated he did not know Resident #95 was a high risk for losing weight. He stated he did not know Resident #95 lost weight prior to his admission and did not realize until reviewing his weights today (03/28/25) that Resident #95 was losing weight. He stated had he known the history and current weight loss, he would have reported the change of condition to the DON. She would then reach out to the Dietician who would implement dietary interventions such as supplemental medication and maybe add double portions for his meals. LVN B stated he recalled calling the PA because Resident #95 had poor appetite upon his admission. The PA added Remeron, an appetite stimulant, but additional interventions would have helped to prevent further weight loss. LVN B stated apparently the Remeron was not sufficient to help Resident #95 from losing weight. LVN B stated the CNA's would report when a resident ate 50% or less of their meal. He stated CNA H had not said anything about Resident #95's intake for breakfast on this date. (continued on next page)

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Interview on 03/28/25 at 11:42 AM with the facility Dietician revealed she met with nursing staff every 2nd week of the month and they discussed residents who were at high risk for weight loss. She stated if a resident was assessed as being a high risk for losing weight from onset then staff would reach out to her to implement a plan including interventions to avoid weight loss. The Dietician stated nursing staff had not reached out to her to report any weight loss for Resident #95. She stated she noted a couple of days ago, during her in-house visit, the resident's weight was trending down. She stated he had not lost any significant weight loss but his weight was trending down. The Dietician stated she added double portions to his meals on 03/27/25. She stated she could also recommend med pass three times a day to prevent further weight loss. The Dietician stated Remeron, an appetite stimulant, was ordered on 2/19/25, but it had not prevented him from losing weight. The Dietician stated there was usually an order to take weekly weights for 4 weeks for new admissions, but she stated she only noted 2 weights entered for Resident #95. She commented they needed to get him back on weekly weights to monitor any additional weight variances so additional interventions were implemented to avoid significant weight loss.

Interview on 03/28/25 at 12:30 PM with the DON revealed there were a lot of systems that were broken. She stated she assumed her position about 1 week ago. She stated usually the DON and ADON's would audit resident records and would discuss any major events that were trending such as falls, weight loss and infections. She stated from what she understood it had not been taking place for a while. She stated she was trying to also improve their internal electronic applications to flag high risks trending events. The DON stated the Dietician called her and alerted her that Resident #95's weight was trending down. She stated the IDT had not discussed Resident's weight loss and usually they did not wait until a resident experienced significant weight loss before they started implementing interventions such as medication supplements and dietary supplements. The DON stated she understood the PA added a new order for Remeron, an appetite stimulant, shortly after Resident #95 was admitted . She stated she understood Resident #95 lost almost 5% after only 2 weeks but also noted upon reviewing his records that he had not been weighed since 3/1/25 so she would not know if had continued to lose weight. The DON stated protocol required nursing staff to weigh new admissions weekly for 4 weeks. The DON stated they did not follow their protocol and did not identify Resident #95 was losing weight and although Remeron was ordered it was not enough to keep him from losing weight.

Review of facility policy, Nutrition, reviewed 7/2024, read It is the policy of this facility to ensure that all residents maintain acceptable parameters of nutritional status, such as body weights and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This facility utilizes an outside Dietary Consultant Group and incorporates its program in the services provided.

PROCEDURES:

Assessment

1. Each resident's nutritional status is assessed on admission and at least quarterly thereafter.

2. Each resident is to be weighed upon admission. weekly, weights for four (4l) weeks and monthly weight thereafter unless otherwise specified by the attending physician. The weight will be entered into the resident's clinical record.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Monthly weights are to be completed and reviewed by the Registered Dietician. Dietary Technician and/or designee. Dietary Evaluation 1. Evaluations may include determining ideal body weight range, usual body weight, current met order, % of food eaten, possible dental problems, and current illnesses, resident likes and dislikes, psychosocial needs. and an other changes in medical condition that may impact weight gain or loss. Once the resident has been evaluated for nutrition status. the Registered Dietitian, Dietary Technician and/or designee will determine if there is a significant change in the resident's condition. If so, additional nutritional intervention will be offered to those residents. Clinical Evaluation 1. Nutritional as easement may include: o Weighing and weight change o Oral intake of food and fluid o IV therapy o Nutrition prescription/macronutrients o Functional status (assistive devices. cueing, hand-over-hand. extensive assistance o Medications (affecting taste, causing anorexia, increasing appetite, causing nausea/vomiting, lethargy. contusion. constipation o Oral health (oral cavity lesions, mouth pain, decayed teeth. poorly filling dentures) o Chewing and swallowing problems o Affective and behavioral disorders o Relevant conditions and diagnosis o Hypermetabolic states (continuous wandering, skin breakdown) o Abnormal labs o Overall prognosis/condition o Resident choice (advance directives) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team to determine the cause of weight loss/gain, intervention required and need for further recommendations and/or referral. Family member/responsible party and attending physician will be notified. 3. Diets will be provided according to physician's orders, including regular and therapeutic diets. Dietician technicians and registered dieticians will make recommendations for therapeutic diets. 4. Care plan will be updated or revised as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 44020 Based on observation, interview, and record review the facility failed to ensure residents who need respiratory care were provided such care, consistent with professional standards of practice for 3 of 6 residents (Residents #76, #85 and #252) were reviewed for respiratory care. 1. Nursing staff failed to clean the oxygen concentrator regularly for Resident #76. 2. Nursing staff failed to clean the oxygen concentrator regularly for Resident #85. 3. Facility failed to ensure Resident #252 had physician orders for oxygen that was observed being used on 03/25/2025 and 03/26/2025. This failure could place residents at risk of illness and respiratory complications. Findings included: 1. Review of Resident #76's face sheet, dated 3/28/25, revealed he was admitted to the facility on [DATE] with a primary diagnosis of Encounter for surgical aftercare following surgery on the digestive system. Review of Resident #76's consolidated physician orders for March 2025 revealed an order for O2 AT 2-4 L/MIN CONTINUOUS PER NC every shift Active 02/21/2025. Review of Resident #76's MDS assessment, dated 2/2/25, revealed Resident #76 was receiving oxygen therapy. Review of Resident #76's Care Plan, initiated on 2/10/25, read Resident #76 has Oxygen Therapy r/t COPD, ACUTE AND CHRONIC RESPIRATORY FAILURE WITH HYPERCAPINA, ACUTE RESPIRATORY FAILURE WITH HYPOXIA, ASTHMA, CHRONIC PULMONARY EDEMA. Interventions included CHANGE O2 TUBING & HUMIDIFIER BOTTLE every night shift every. Thursday for maintenance. Observation on 03/27/25 at 02:50 PM revealed Resident #76 lying in bed; he woke up as soon as knocked on the door. Further observation revealed Resident #76 was receiving oxygen at 2 liters per minute. The oxygen concentrator was full of white dust all over including on the vent port where the filter was placed. Interview on 03/27/25 at 03:20 PM with LVN B revealed night staff would change the tubing/humidifier on the oxygen concentrators. He stated nursing staff should also clean the filter and concentrator casing to keep Resident #76 from inhaling dust particles which could cause an infection. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 03/27/25 at 03:27 PM reveled Resident #76 receiving oxygen at 2 liters per minute via nasal cannula. Interview with LVN I commented, oh yeah it's dirty. She stated the filter was inside behind the vent port and stated dirt could be circulated inside the concentrator and cause Resident #76 an infection or have other respiratory problems. 2. Review of Resident #85's face sheet, dated 3/27/25, reviewed she was admitted to the facility on [DATE] with diagnoses including Chronic Respiratory Failure with Hypercapnia (according to Mayo clinic, Respiratory failure is a condition where you don ' t have enough oxygen in the tissues in your body (hypoxia) or when you have too much carbon dioxide in your blood (hypercapnia) and Chronic Pulmonary Edema (according to Mayo clinic, condition caused by too much fluid in the lungs). Review of Resident #85's consolidated physician orders for March 2025 revealed an order, O2 AT 2-4L/MIN CONTINUOUS PER NC every shift Active 1/31/2025. Review of Resident #85's admission MDS, dated [DATE], revealed Resident's BIMS was 15 of 15 indicating no cognitive impairment. Review of Resident #85's Care Plan initiated on 2/4/25, revealed she used Oxygen Therapy r/t Respiratory illness. One of the interventions included CHANGE O2 TUBING & HUMIDIFIER BOTTLE every night shift every. Thursday for maintenance. Observation on 03/25/25 at 10:22 AM revealed a black oxygen concentrator between A bed and the nightstand. It was full of dust. Observation and interview on 03/26/25 at 10:59 AM revealed Resident #85 lying in bed with oxygen infusing at 2 liters per minute via nasal cannula. Resident #85's family member stated he saw staff coming in periodically to check on the concentrator. Observation and interview on 03/26/25 at 11:28 AM revealed 02 concentrator with white speckles all over it including around the outer vent portal containing the filter Observation and interview on 03/27/25 at 03:25 PM with LVN I revealed she was wiping Resident #85's concentrator down. She stated it was very dusty. LVN I stated the filter was inside behind the vent portal and stated dirt could be circulated inside the concentrator and cause Resident #85 an infection or to have other respiratory problems. Interview on 03/28/25 at 12:30 PM with the DON revealed nursing staff was supposed to clean the filter and the concentrator casing to keep dust from building up. She stated she was not sure if they would clean the filter if it was located within the concentrator. She stated the company who they rented the concentrators from might service them, but did not know if they had serviced them. The DON stated it was important to keep the filter and the casing clean so the residents did not inhale dust or other contaminants because the residents could get an infection or it could cause other respiratory complications. The DON stated she was also aware the physician orders and care plans did not include to clean the filter and the oxygen casing but both should include the cleaning of the items. 3. Record review of Resident #252's face sheet, dated 03/25/2025, revealed Resident #252 was admitted on [DATE] with a diagnosis of shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #252's Admission MDS, dated [DATE], was still in progress. Record review of Resident #252's IDT-BIMS dated 03/18/2025, revealed Resident #252's BIMS score was 08 for moderately cognitive impairment. Record review of Resident #252's undated care plan revealed no focus or interventions for oxygen therapy. Record review of Resident #252's physician order summary report, dated 03/25/2025, revealed no orders for oxygen use. Record review of Resident #252's nurse practitioner notes, dated 03/18/2025, read Initial History and Physical, Interval: Nurse reports concerns for drowsiness and low oxygen. Patient initially wakes for short period on exam, answering minimal questions. Oxygen sat 99% on exam, 2L O2 in place. Record review for Resident #252's electronic health record revealed under weights & vitals it was documented Resident #252 was wearing oxygen on 03/24/2025 at 9:27 a.m., 03/24/2025 at 2:17 p.m., 03/25/2025 at 2:00 p.m., and on 03/26/2025 at 2:53 p.m. by unknown nurse. Observation and interview on 03/25/2025 at 11:06 a.m. revealed Resident #252 lying in bed with oxygen on and nasal cannula off to the right side of his nose. He stated it moves around and they always come and fix it fussing over it. Resident #252's oxygen concentrator was set at 2.5 liters with tubing dated 03/21/2025. Observation and interview on 03/26/2025 at 3:19 p.m. revealed Resident #252 lying in bed with the head of his bed elevated, oxygen nasal cannula to the side of left side of his head on the bed, and concentrator set at 2.5 liters. Resident #252 denied any trouble breathing and did not seem to be in distress. Interview and observation on 03/26/2025 at 3:26 p.m. LVN E stated Resident #252's oxygen was PRN. LVN E further stated Resident #252 would let them know when he needed the oxygen and believed it was to be set at 2 liters or 2.5 liters. LVN E then proceeded to turn off the concentrator as she spoke. LVN E was observed using a pulse-ox (a non-invasive medical procedure that measures the oxygen saturation of the blood) and stated Resident #252's hands were really cold and was not getting a reading on the pulse-ox. LVN E asked Resident #252 if he was breathing okay and if he was cold of which he stated he was fine. LVN E reviewed of Resident #252's orders at her medication cart. LVN E revealed resident did not have an order for his oxygen. LVN E stated Resident #252 was usually in the high 90's for her when she would check his oxygen saturations and had not had to use the oxygen during her shift. LVN E further stated usually the orders would read to start oxygen at 2 liters and to administer below 91 or 92 depending on the physician. LVN E stated she would have to contact the physician prior to administering oxygen if his oxygen saturations were low. During an interview on 03/26/2025 at 3:48 p.m. the DON revealed Resident #252 did not have orders for oxygen and he should have had them as it had been used. The DON stated orders gave structure on how to administer, and the liters that should be used. The DON further stated nursing would start oxygen, then call the physician if a resident needed oxygen and would get a clarification order. The DON stated she believed Resident #252 had a change and that he was also tested Flu at the time the oxygen was started, however she was not sure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/27/2025 at 2:22 p.m. revealed Resident #252's oxygen concentrator had been removed from his room. During an interview on 03/27/2025 at 3:45 p.m. the DON stated the oxygen was removed yesterday from resident's room after an assessment was performed revealing Resident #252 did not want the oxygen and he was not hypoxic. During an interview on 03/28/2025 5:09 p.m. the administrator stated the nurses were responsible for getting the orders for oxygen as soon as there was change or it was needed. Record review of facility's policy titled Oxygen Administration, revised 01/2025, read Policy: It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. Review of an oxygen manual which Resident #76 and Resident #85 used read in relevant part Caring for your [name] oxygen concentrator. Filter door with vents. Inspect the vents periodically and wipe with a dry cloth as needed to remove dust. Service and maintenance should only be performed by appropriately trained and authorized [name] personnel and/or service centers.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to assess the resident for risk of entrapment from bed rails prior to installation; review the risks and benefits of bed rails with the resident or resident representative for 2 of 8 residents (Resident #85 and Resident 95) whose records were reviewed. Nursing staff failed to assess Resident #85 and Resident #95 for the use of side rails, discuss the risks versus benefits of using side rails with the resident and or representative upon admission. This deficient practice could affect residents who used side rails and could contribute to avoidable injuries. The findings were: 1. Review of Resident #85's face sheet, dated 3/27/25, reviewed she was admitted to the facility on [DATE] with diagnoses including Chronic Respiratory Failure with Hypercapnia (according to Mayo clinic, Respiratory failure is a condition where you don ' t have enough oxygen in the tissues in your body (hypoxia) or when you have too much carbon dioxide in your blood (hypercapnia). and Chronic Pulmonary Edema (according to Mayo clinic, condition caused by too much fluid in the lungs). Review of Resident #85's consolidated physician orders for March 2025 revealed an order, MAY USE 1/4 BILATERAL MOBILITY BARS TO AIDE IN EASY TURNING & REPOSITIONING WHILE IN BED. Review of Resident #85's assessments revealed there was not an assessment for the use of side rails or any documentation to support nursing staff discussed the risks versus the benefits of using the side rails. Review of annual MDS, dated [DATE], revealed Resident's BIMS was 15 of 15 indicating no cognitive impairment. Review of Resident's CP, revised on 2/13/25, revealed there was no indication she used a SR for repositioning and mobility. Interview on 03/27/25 at 03:53 PM MDS Coordinator/LVN G revealed there was not an assessment for the use of side rails for Resident #85. Interview on 03/28/25 at 12:30 PM with the DON revealed nursing staff was required to, conduct an assessment, to explain the benefits versus the risks of using the side rails and to obtain a consent for the use of side rails from a resident or family representative upon admission or at the time the side rails would be used for repositioning and or bed mobility. She stated it was important to determine whether a resident could safely use the side rails to avoid any accidents or injuries. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #95's face sheet, dated 3/28/25, revealed he was admitted to the facility on [DATE] with diagnoses including Encephalopathy (according to Mayo Clinic, is a general term describing a disease that affects the function or structure of your brain), Respiratory Failure and Sepsis (according to Mayo clinic, is a serious condition in which the body responds improperly to an infection). Review of Resident #95's admission MDS assessment, dated 2/19/25, revealed his BIMS score was 8 reflective of moderate cognitive impairment. Review of Resident #95's Care Plan, revised on 2/28/25, read Resident #95 has an ADL Self Care Performance Deficit r/t weakness. One of the interventions included Utilizes mobility bars as an enabler in Bed Mobility. Review of physician orders for March 2025 revealed an order for MAY USE 1/4 MOBILITY BARS TO AIDE IN EASY TURNING &REPOSITIONING WHILE IN BED every shift Phone Active 02/15/2025. Observation and interview on 03/25/25 at 10:00 AM revealed Resident #95 was lying in bed with quarter side rails up on both sides of the bed. Observation and interview on 03/27/25 at 03:00 PM revealed Resident #95 sitting in a wheelchair with 1/4 side rails up on both sides of the bed. Resident #95 stated used side rails to lean his back on them so could lie at an angle. Resident #95 stated he did not remember anyone talking to him about the side rails. Interview on 03/28/25 at 12:30 PM with the DON revealed nursing staff was required to, conduct an assessment, to explain the benefits versus the risks of using the side rails and to obtain a consent for the use of side rails from a resident or family representative upon admission or at the time the side rails would be used for repositioning and or bed mobility. She stated it was important to determine whether a resident could safely use the side rails to avoid any accidents or injuries. Review of facility policy, Nursing Administration, revised 10/2024, read It is the policy of this facility that the resident has the right to be free from any physical or chemical restraint for purposes of discipline or convenience, and not required to treat resident's medical symptoms. Purpose: To attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstance in which the resident has a medical symptom that warrant the use of restraints. Procedures: 1. A physician's order is necessary for the use of a physical restraint. 2. The use of a restraining device must first be explained to the resident, family member, or legal representative. 3. The facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Use of side rails as restraints is prohibited unless necessary to treat a resident's medical symptoms. 6. Medical symptoms that warrant the use of restraints must be documented in the resident's medical record, ongoing assessments, and care plans. 7. A device that does not prevent the resident from getting out of bed, or from movement, and or the resident can remove with minimal effort is not considered a restraint.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 residents (Resident #43), reviewed for pharmacy services. The facility did not have Resident #43's ordered PRN (as needed) hydrocodone (pain medication) available for 9 days from his admission on 2/28/25 to his discharge on 3/8/25. This failure could place the residents at risk of pain and not receiving needed care and services. The findings were: Record review of Resident #43's face sheet dated 3/26/25 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE], discharged to the hospital on 2/18/25 and readmitted on [DATE]. His diagnoses included metabolic encephalopathy (diffuse disease of the brain that alters brain function or structure caused by metabolic changes due to underlying health conditions), acute pulmonary edema (a condition caused by excess fluid in the lungs. This fluid collects in the numerous air sacs in the lungs, making it difficult to breathe), pressure ulcer of sacral region stage III (localized skin and soft tissue injuries that develop due to prolonged pressure exerted over specific areas of the body, typically bony prominences, Stage III=A full-thickness loss of skin extends to the subcutaneous tissue but does not cross the fascia beneath it). The resident was discharged on [DATE]. Record review of Resident #43's annual MDS assessment dated [DATE] revealed the resident had a BIMS of 8 out of 15 indicating the resident was moderately cognitively impaired. The resident did not receive scheduled pain medication but did receive PRN pain medication for occasional pain and had pain intensity at a level of 5 and it interfered with his sleep, and day to day activities rarely or not at all. Record review of Resident #43's 5-day scheduled MDS assessment dated [DATE] revealed the resident had a BIMS of 8 out of 15 indicating the resident was moderately cognitively impaired. The resident did not receive scheduled pain medication and had not received PRN pain medications. The resident had received non medication interventions for pain but had no pain. The rest of the pain questions were blank. Record review of Resident #43's undated care plan did not have a focus or interventions for pain. Record review of Resident #43's physician orders revealed an order with a start date of 2/28/25 and a discontinue date of 3/10/25 for hydrocodone-acetaminophen 10-325 mg (milligram) give 1 tablet by mouth every 6 hours as needed for pain. Record review of Resident #43's physician orders revealed an order with a start date of 2/28/25 and a discontinue date of 3/10/25 for acetaminophen 650mg by mouth every 6 hours as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #43's EMAR for February 2025 revealed on 2/28/25, the resident received a non-pharmacological intervention for pain of a code 2, which indicated rest. Record review of Resident #43's EMAR for March 2025 revealed the resident received a non-pharmacological intervention for pain of a code 2, which indicated rest on 3/1/25, and 3/2/25 for day, evening, and night shifts. Record review of Resident #43's EMAR for March 2025 revealed on 3/7/25 at 3:23 p.m. the resident received acetaminophen 650mg for a pain level of 4 and was effective. The resident also received this same dose on 3/8/25 at 10:24 a.m. for a pain level of 2 and was effective. Record review of Resident #43's EMAR for March 2025 revealed no hydrocodone was administered to the resident for the month of March 2025. Record review of Resident #43's EMAR for February of 2025 during his previous stay at the facility from 2/11/25 to 2/18/25 the resident received the same dose of hydrocodone on 2/12/25 at 11:36 a.m. for a pain level of 5 that was effective and again on 2/15/25 at 8:25 p.m. for a pain level of 8 that was effective. Record review of Resident #43's progress notes revealed a nursing note dated 3/8/25 at 2:27 p.m. by RN A Authorization to pull prn medication denied due to no active script of file at pharmacy. MD to be made aware. Record review of Resident #43's progress notes revealed a nursing note dated 3/8/25 at 5:16 p.m. by RN A the resident's physician had been notified the PRN medication was not delivered and the physician had sent the prescription to the pharmacy. In an anonymous interview it was stated Resident #43 was observed to be in pain on 3/8/25 and was moaning and groaning and hydrocodone was requested from RN A. It was stated RN A medicated the resident and when Resident #43 asked what the medication was RN A answered it was Tylenol (acetaminophen) and the resident took it. When questioned about the hydrocodone because they felt the resident needed something stronger than acetaminophen RN A stated the facility did not have any hydrocodone for Resident #43 and had run out. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/28/25 at 9:31 a.m. RN A stated he remembered Resident #43 and on 3/8/25 a family member was requesting the resident's ordered hydrocodone pain medication for the resident and there was no hydrocodone for the resident. RN A stated he attempted to pull the hydrocodone from the emergency kit and it was denied due to no prescription on file with the pharmacy. RN A stated he called the pharmacy to find out what was going on and the pharmacy told RN A they did not have an active prescription for the resident's hydrocodone. RN A stated he immediately called the physician directly and the physician had informed RN A that he had sent the electronic prescription to the pharmacy many times and would send again. RN A stated there had been issues during the week with the same thing and he had overheard LVN B attempting to get Resident #43's hydrocodone during the weekday the previous week. RN A stated he called the pharmacy again and there was no prescription per the pharmacy. RN A stated he called the physician again and the physician sent RN A proof that he had sent it to the pharmacy. RN A then called the pharmacy again and it was determined that it had not gone to the right place within the pharmacy and the physician was notified and sent it to the correct place. RN A stated he verified with the pharmacy they had received it and were entering it and he would be able to pull it from the emergency kit soon. RN A stated the resident was sleeping and did not appear to be in pain, and he was not noted to be moaning and groaning except when turning the resident and he gave the resident Tylenol while waiting, but the family was getting frustrated. The resident was sent to the hospital for evaluation at the family's request prior to giving the pain medication. RN A stated the resident's previous hydrocodone was not on site at the facility and he was unsure why. In an interview on 3/28/25 at 1:59 p.m. LVN B stated he remembered Resident #43 and had notified the Dr. about the pharmacy stating they did not have the hydrocodone prescription several times but unsure of the dates and times. LVN B stated he checked the facility discontinued medications for Resident #43's previous hydrocodone stock but the previous hydrocodone had been turned in and destroyed during the pharmacist visit while the resident was in the hospital. LVN B stated the resident did not complain of pain during that time but LVN B continued to attempt to get the hydrocodone to the facility as it was ordered. LVN B stated the resident worked with therapy and never complained of pain nor did his assessment indicate pain. LVN B stated different physicians have different protocols and for Resident #43, the nurses were to contact his physician directly and the physician was sending the prescription each time and it ended up being an error. LVN B stated he was unsure if the prescription went to the wrong pharmacy or it was an electronic submission error. LVN B stated the resident would only moan or groan when turned or repositioned but not like he was in pain. In an interview on 3/28/25 at 4:20 p.m. MD P stated he did not feel the resident was harmed due to not having his hydrocodone. MD P stated he had cared for the resident since his long-term acute care hospital stay prior to his admission to the facility and he had examined him at the facility on his last admission and his assessment did not reveal the resident was in any pain. In an interview on 3/28/25 at 4:45 p.m. the DON stated if a medication were not available for a resident the expectation was the nurse would notify the physician as soon as possible whether it was a new order or a reordered medication. The DON stated the nurse should call the pharmacy and try to find out what happened to the medication delivery and notify the physician. The DON stated the possible consequences of a resident not having their PRN pain medication available would be the resident could have pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy on pharmaceutical services reviewed 12/2024, under policy was It is the policy of this facility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. And under procedures was The pharmacist, in collaboration with the facility and the medical director helps develop and evaluate the implementation of pharmaceutical services procedures that address the needs of the residents, are consistent with state and federal requirements and reflect current standards of practice.

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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. 46677 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were secured properly within 2 of 4 medication carts (med cart in hall 300 and med cart in hall 400) observed for medication storage. One unidentified small round white pill was observed in the bottom drawer of the medication cart on 400 hall. Two unidentified small round white pills were observed in the top drawer of the medication cart on 300 hall. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications as ordered. The findings were: Observation of the medication cart on 400 hall on 03/27/2025 at 2:30 PM revealed a small round white pill on the bottom of the bottom drawer of the medication cart on 300 hall. The pill was loose and not labeled with no identifying markers to indicate what it was. Medication cart was locked and secured. Observation of the medication cart on 300 hall on 03/27/2025 at 3:10 PM revealed two small round white pills on the bottom of the top drawer of the medication cart on 300 hall. The pills were loose and not labeled with no identifying markers to indicate what they were. Medication cart was locked and secured. Interview with CMA C on 03/27/2025 at 2:55 PM revealed CMA C could not identify loose pills located in medication carts for the 300 halls and 400 halls. CMA C stated if a loose pill is found in the medication carts staff are to follow the facility policy to dispose of them. CMA C stated loose pills in the medication carts could cause the resident's to go without necessary medications. Interview with DON on 03/27/2025 at 3:41 PM revealed medications are to be stored in original packaging. DON stated CMAs check the carts daily to ensure they are clean and there are no loose pills. DON stated loose pills in the medication carts would not affect the residents since staff would now dispense loose pills. Record review facility policy titled [Facility Name] Policy/ Procedure - Nursing Clinical section Care and Treatment subject Medication Access and Storage, E kit access, revised 07/2024, revealed 1. The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers.

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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 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. 44020 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. The facility failed to ensure dietary staff used proper hand placement and hand hygiene during plate preparation. The facility failed to ensure a divided plate was properly dried prior to serving a grilled cheese sandwich in it. This failure could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 03/25/2025 at 11:47 a.m. revealed [NAME] F washing hands prior to the meal service, however, [NAME] F, proceeded to review the diet tickets, handling diet tickets as he reviewed and then began to prepare resident plates. While serving [NAME] F would reach for the souffle bowls, grabbing the bowls by placing thumb or fingers on the inner side of the bowl. [NAME] F was further observed to grab divided plates and placed thumb or fingers inside a section of the plate while picking up the plate. [NAME] F was then observed placing the diet tickets on top of the serving bar next to the plates for the dietary aide to place on trays between servings. During an interview on 03/26/2025 at 11:55 a.m. the dietary supervisor stated the meal tickets would not be considered a clean item when handling them prior to serving. The dietary supervisor further stated the cook placing his fingers in the bowls or plates could cause cross contamination. During an interview on 03/26/2025 at 12:02 p.m. [NAME] F stated by placing fingers or thumbs in the bowls or plates was not clean. [NAME] F further stated by doing this could affect residents by putting them at risk of getting sick. Observation on 03/27/2025 at 12:13 p.m. revealed during plate preparation and tray service a divided plate sitting in an insulated base, on top of the plate warmer, with water droplets and pooling of water in the different sections of the divided plate. The dietary supervisor was observed placing a grilled cheese sandwich in the divided plate that had not air dried properly and then the plate was placed on a tray. Observation and interview on 03/27/2025 at 12:17 p.m. trays were observed leaving the kitchen and tray cart followed to the dining room, grilled cheese sandwich served in the dining room. Resident was observed eating the sandwich with no voiced concerns. The dietary resource was present when cover was removed and identified the divided plate had not fully been dried prior to being used. Dietary resource stated the kitchen air dries all dishes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/2025 at 2:25 p.m. the dietary resource stated the divided dish by not having been dried fully and having been served with standing drops of water could cause cross contamination. The dietary resource further stated it could make residents very sick. The dietary resource stated the plate should have been pulled once the liquid was seen and not served. The dietary resource stated she was too focused on checking other divided plates in the kitchen and did not take the plate that was served. During an interview on 03/27/2025 at 2:31 p.m. the dietary supervisor stated he did not notice the water in the divided plate when he served the grilled cheese sandwich but stated it could cause cross contamination. The dietary supervisor further stated the dishes are air dried. During an interview on 03/28/2025 at 4:59 p.m. the DON stated there was the potential of cross contamination of food by dishes not being dried thoroughly. The DON further stated it could have the potential for causing infections. The DON stated she felt it would be multiple people's responsibility to not serve food on improperly dried plates if it was not caught in the kitchen the other staff should catch in passing of trays. During an interview on 03/28/2025 at 5:11 p.m. the administrator stated residents could get sick if there was cross contamination from not properly handling the dishes. The administrator further stated the dietary supervisor was responsible to ensure dishes were air dried and even the cook on duty was responsible. Review of facility's policy Handling Clean Equipment and Utensils, not dated, read Policy: Clean equipment and utensils will be handled properly to prevent contamination. Procedure: 1. When handling cleaned and sanitized equipment, staff will avoid touching the parts that will come in contact with the food. Review of facility's policy Cleaning Dishes/Dish Machine, not dated, read Policy: All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use .Procedures: 9. Dishes should be air dried on the dish racks .10. Inspect for cleanliness and dryness and put dishes away if clean. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-301.14, When to Wash, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTNESILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 46677 Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 1 (Cook D) of 28 employees reviewed for training requirements. The facility failed to implement and maintain a training program that ensured [NAME] D received required trainings upon hire and annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. Findings include: Record review of the personnel records for [NAME] D revealed a hire date of 12/16/2023. Further review of a training log for [NAME] D from the previous 15 months, provided by the HR Manager revealed no evidence of communication training, resident rights training, QAPI training, infection control training, ethics training, behavior health training, dementia training, HIV training, falls training, restraint training or emergency preparedness training being provided annually prior to March 25, 2025. Training log for [NAME] D revealed annual trainings were last completed: - communication training completed 01/25/2024 - resident rights training completed 02/06/2024 - QAPI training completed 01/26/2024 - infection control training completed 01/26/2024 - ethics training completed 01/25/2024 - behavior health training completed 01/26/2024 - dementia training completed 01/26/2024 - HIV training completed 01/26/2024 - falls training completed 01/26/2024 - restraint training completed 02/23/2024 - emergency preparedness training completed 01/26/2024 (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with HR Manager on 03/28/2025 at 4:35 PM revealed facility relies on the training program Relias to identify staff that have annual trainings due within 30 days. HR Manager stated he runs a weekly report in Relias to identify employees that need to complete annual trainings. HR Manager stated that [NAME] D did not show up on any reports of the weekly reports. HR manager stated it was his responsibility to run the weekly reports and to provide them to the department heads who are responsible to ensure their staff complete trainings. HR Manager stated by not training staff annually it increased the likelihood that a staff member could do something wrong and put the residents in harms way. Interview with Administrator on 03/28/2025 at 4:48 PM revealed HR and Administrator are to ensure staff receive their annual trainings. The Administrator stated a report is run in Relias to identify staff who have trainings that are due in the next 30 days, and it is the responsibility of department heads to ensure staff complete trainings. The Administrator stated staff are required to complete trainings to ensure they are up to date on policies and procedures to ensure quality care is being provided. The Administrator stated if staff are not trained it puts resident at risk for receiving poor care. Record review of facility policy titled In Service Training Program, dated April 2004, revealed 8. The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): A. Problems and needs of the aged chronically ill, acutely ill, and disabled patients B. Prevention and control of infections C. Interpersonal relationship and communication skills D. Fire prevention and safety E. Accident prevention and safety measures F. Confidentiality of patient information G. Preservation of patient dignity, including provision for privacy H. Patient rights and civil rights I. HIPAA J. Signs and symptoms of cardiopulmonary distress K. Choking prevention and intervention L. Sexual Harassment M. Elder Abuse and residents rights N. Blood borne pathogens (HIV, Hepatitis B) (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	O. Hazard communication (Material Safety Data Sheets, [MSDS]) P. Resident assessment (MOS, PASARR, PSYCH, Diags.) Q. Restraints R. ADA (American Disabilities Act) A policy addressing required annual training including QAPI training, ethics training, behavior health training, dementia training, HIV training and fall prevention training was requested from the HR Manager on 03/28/2025 at 4:35 PM but was not provided prior to exit. A policy addressing required annual training including QAPI training, ethics training, behavior health training, dementia training, HIV training and fall prevention training was requested from the Administrator on 03/28/2025 at 4:48 PM but was not provided prior to exit.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 46677 Based on interview and record review, the facility failed to provide mandatory effective communications training for 1 (Cook D) of 28 employees reviewed for training. The facility failed to ensure effective communication training was provided to [NAME] D annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. Findings include: Record review of the personnel records for [NAME] D revealed a hire date of 12/16/2023. Further review of a training log for [NAME] D from the previous 15 months, provided by the HR Manager revealed no evidence of communication training being provided annually prior to March 25, 2025. The training log for [NAME] D revealed annual training of effective communication training was last completed 01/25/2024. Interview with HR Manager on 03/28/2025 at 4:35 PM revealed the facility relied on the training program Relias to identify staff who had annual trainings due within 30 days. The HR Manager stated he ran a weekly report in Relias to identify employees who needed to complete annual trainings. The HR Manager stated [NAME] D did not show up on any reports of the weekly reports. The HR manager stated it was his responsibility to run the weekly reports and to provide them to the department heads who were responsible to ensure their staff completed trainings. The HR Manager stated by not training staff annually it increased the likelihood that a staff member could do something wrong and put the residents in harm's way. Interview with the Administrator on 03/28/2025 at 4:48 PM revealed HR and the Administrator were to ensure staff received their annual trainings. The Administrator stated a report was run in Relias to identify staff who had trainings that were due in the next 30 days, and it was the responsibility of the department heads to ensure staff completed trainings. The Administrator stated staff were required to complete trainings to ensure they were up to date on policies and procedures to ensure quality care was being provided. The Administrator stated if staff were not trained it put resident at risk for receiving poor care. Record review of facility policy titled In Service Training Program, dated April 2004, revealed 8. The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): A. Problems and needs of the aged chronically ill, acutely ill, and disabled patients B. Prevention and control of infections C. Interpersonal relationship and communication skills (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Fire prevention and safety E. Accident prevention and safety measures F. Confidentiality of patient information G. Preservation of patient dignity, including provision for privacy H. Patient rights and civil rights I. HIPAA J. Signs and symptoms of cardiopulmonary distress K. Choking prevention and intervention L. Sexual Harassment M. Elder Abuse and residents rights N. Blood borne pathogens (HIV, Hepatitis B) O. Hazard communication (Material Safety Data Sheets, [MSDS]) P. Resident assessment (MOS, PASARR, PSYCH, Diags.) Q. Restraints R. ADA (American Disabilities Act)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 46677 Based on interview and record review, the facility failed to provide mandatory training on Dementia management training for 1 (Cook D) of 28 employees reviewed for training. The facility failed to ensure Dementia management training was provided to [NAME] D annually. This failure could place residents at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for [NAME] D revealed a hire date of 12/16/2023. Further review of a training log for [NAME] D from the previous 15 months, provided by the HR Manager revealed no evidence of dementia training being provided annually prior to March 25, 2025. The training log for [NAME] D revealed annual dementia trainings was last completed on 01/26/2024. Interview with the HR Manager on 03/28/2025 at 4:35 PM revealed the facility relied on the training program Relias to identify staff who had annual trainings due within 30 days. The HR Manager stated he ran a weekly report in Relias to identify employees who needed to complete annual trainings. The HR Manager stated [NAME] D did not show up on any reports of the weekly reports. The HR manager stated it was his responsibility to run the weekly reports and to provide them to the department heads who were responsible to ensure their staff completed trainings. The HR Manager stated by not training staff annually it increased the likelihood a staff member could do something wrong and put the residents in harm's way. Interview with the Administrator on 03/28/2025 at 4:48 PM revealed HR and Administrator were to ensure staff received their annual trainings. The Administrator stated a report was run in Relias to identify staff who had trainings that were due in the next 30 days, and it was the responsibility of the department heads to ensure staff completed trainings. The Administrator stated staff were required to complete trainings to ensure they were up to date on policies and procedures to ensure quality care was being provided. The Administrator stated if staff were not trained it put residents at risk for receiving poor care. A policy addressing required annual training including dementia training was requested from the HR Manager on 03/28/2025 at 4:35 PM but was not provided prior to exit. A policy addressing required annual training including dementia training was requested from the Administrator on 03/28/2025 at 4:48 PM but was not provided prior to exit.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 46677 Based on interview and record review the facility failed to include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of it's QAPI program for 1 (Cook D) of 28 employees reviewed for training requirements. The facility failed to ensure required QAPI trainings was provided to [NAME] D annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. Findings include: Record review of the personnel records for [NAME] D revealed a hire date of 12/16/2023. Further review of a training log for [NAME] D from the previous 15 months, provided by the HR Manager revealed no evidence of QAPI training being provided annually prior to March 25, 2025. The training log for [NAME] D revealed annual QAPI training was last completed on 01/26/2024. Interview with the HR Manager on 03/28/2025 at 4:35 PM revealed the facility relied on the training program Relias to identify staff who had annual trainings due within 30 days. The HR Manager stated he ran a weekly report in Relias to identify employees who needed to complete annual trainings. The HR Manager stated [NAME] D did not show up on any reports of the weekly reports. The HR manager stated it was his responsibility to run the weekly reports and to provide them to the department heads who are responsible to ensure their staff completed trainings. The HR Manager stated by not training staff annually it increased the likelihood that a staff member could do something wrong and put the residents in harm's way. Interview with the Administrator on 03/28/2025 at 4:48 PM revealed HR and the Administrator were to ensure staff received their annual trainings. The Administrator stated a report was run in Relias to identify staff who had trainings that were due in the next 30 days, and it was the responsibility of department heads to ensure staff completed trainings. The Administrator stated staff were required to complete trainings to ensure they were up to date on policies and procedures to ensure quality care was being provided. The Administrator stated if staff were not trained it put residents at risk for receiving poor care. A policy addressing required annual training including QAPI training was requested from the HR Manager on 03/28/2025 at 4:35 PM but was not provided prior to exit. A policy addressing required annual training including QAPI training was requested from the Administrator on 03/28/2025 at 4:48 PM but was not provided prior to exit.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 46677 Based on interview and record review, the facility failed to include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program for 1 (Cook D) of 28 employees reviewed for training. The facility failed to ensure standards, policies, and procedures for an infection prevention and control program training was provided [NAME] D annually. This failure could place residents at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for [NAME] D revealed a hire date of 12/16/2023. Further review of a training log for [NAME] D from the previous 15 months, provided by the HR Manager revealed no evidence of infection control training being provided annually prior to March 25, 2025. The training log for [NAME] D revealed annual infection control trainings was last completed on 01/26/2024. Interview with the HR Manager on 03/28/2025 at 4:35 PM revealed the facility relied on the training program Relias to identify staff who have annual trainings due within 30 days. The HR Manager stated he ran a weekly report in Relias to identify employees who needed to complete annual trainings. The HR Manager stated [NAME] D did not show up on any reports of the weekly reports. The HR manager stated it was his responsibility to run the weekly reports and to provide them to the department heads who are responsible to ensure their staff complete trainings. The HR Manager stated by not training staff annually it increased the likelihood that a staff member could do something wrong and put the residents in harm's way. Interview with the Administrator on 03/28/2025 at 4:48 PM revealed HR and the Administrator were to ensure staff received their annual trainings. The Administrator stated a report was run in Relias to identify staff who had trainings that were due in the next 30 days, and it was the responsibility of the department heads to ensure staff completed trainings. The Administrator stated staff were required to complete trainings to ensure they were up to date on policies and procedures to ensure quality care was being provided. The Administrator stated if staff were not trained it put resident at risk for receiving poor care. Record review of facility policy titled In Service Training Program, dated April 2004, revealed 8. The following in-service training classes are mandatory (i.e., each employee must attend a training class on each of the following topics): A. Problems and needs of the aged chronically ill, acutely ill, and disabled patients B. Prevention and control of infections

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. 46677 Based on interview and record review, the facility failed to provide mandatory ethics training for 1 (Cook D) of 28 employees reviewed for training. The facility failed to ensure ethics training was provided to [NAME] D annually. This failure could place residents at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for [NAME] D revealed a hire date of 12/16/2023. Further review of a training log for [NAME] D from the previous 15 months, provided by the HR Manager revealed no evidence of ethics training being provided annually prior to March 25, 2025. The training log for [NAME] D revealed annual ethics trainings was last completed on 01/25/2024. Interview with the HR Manager on 03/28/2025 at 4:35 PM revealed the facility relied on the training program Relias to identify staff who had annual trainings due within 30 days. The HR Manager stated he ran a weekly report in Relias to identify employees who needed to complete annual trainings. The HR Manager stated [NAME] D did not show up on any reports of the weekly reports. The HR manager stated it was his responsibility to run the weekly reports and to provide them to the department heads who were responsible to ensure their staff completed trainings. The HR Manager stated by not training staff annually it increased the likelihood that a staff member could do something wrong and put the residents in harm's way. Interview with the Administrator on 03/28/2025 at 4:48 PM revealed HR and the Administrator were to ensure staff received their annual trainings. The Administrator stated a report was run in Relias to identify staff who had trainings that were due in the next 30 days, and it was the responsibility of department heads to ensure staff completed trainings. The Administrator stated staff were required to complete trainings to ensure they were up to date on policies and procedures to ensure quality care was being provided. The Administrator stated if staff were not trained it put resident at risk for receiving poor care. A policy addressing required annual training including ethics training was requested from the HR Manager on 03/28/2025 at 4:35 PM but was not provided prior to exit. A policy addressing required annual training including ethics training was requested from the Administrator on 03/28/2025 at 4:48 PM but was not provided prior to exit.

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 46677 Based on interview and record review, the facility failed to provide behavioral health training consistent with the requirements at S483.40 and as determined by the facility assessment at S483.71 for 1 (Cook D) of 28 employees reviewed for training. The facility failed to ensure behavioral health training was provided to [NAME] D annually. This failure could place residents at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for [NAME] D revealed a hire date of 12/16/2023. Further review of a training log for [NAME] D from the previous 15 months, provided by the HR Manager revealed no evidence of behavior health training being provided annually prior to March 25, 2025. The training log for [NAME] D revealed annual behavior health training was last completed 01/26/2024. Interview with the HR Manager on 03/28/2025 at 4:35 PM revealed the facility relied on the training program Relias to identify staff who had annual trainings due within 30 days. The HR Manager stated he ran a weekly report in Relias to identify employees who needed to complete annual trainings. The HR Manager stated [NAME] D did not show up on any reports of the weekly reports. The HR manager stated it was his responsibility to run the weekly reports and to provide them to the department heads who were responsible to ensure their staff completed trainings. The HR Manager stated by not training staff annually it increased the likelihood a staff member could do something wrong and put the residents in harm's way. Interview with the Administrator on 03/28/2025 at 4:48 PM revealed HR and the Administrator were to ensure staff received their annual trainings. The Administrator stated a report was run in Relias to identify staff who had trainings that were due in the next 30 days, and it was the responsibility of the department heads to ensure staff completed trainings. The Administrator stated staff were required to complete trainings to ensure they were up to date on policies and procedures to ensure quality care was being provided. The Administrator stated if staff were not trained it put resident at risk for receiving poor care. A policy addressing required annual training including behavior health training was requested from the HR Manager on 03/28/2025 at 4:35 PM but was not provided prior to exit. A policy addressing required annual training including behavior health training was requested from the Administrator on 03/28/2025 at 4:48 PM but was not provided prior to exit.