STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676413	A. Building B. Wing	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Garland	2625 Belt Line Road Garland, TX 75044

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interview and record review the facility failed to ensure residents had the right to participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 1 of 6 residents (Resident #28) reviewed for resident rights. The facility failed to obtain a signed informed consent based on information of the benefits, risks, and options available for Resident #28 prior to administering Lamictal (medicine to treat seizures and bipolar disorder). This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party or being aware of the risk of the medications prescribed. Findings included: Record review of Resident #28's quarterly MDS assessment, dated 12/14/23, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. The resident was understood and able to understand others. The resident's diagnoses included Alzheimer's disease. Record review of the care plans for Resident #33, not dated, revealed no focus areas for the medication Lamictal. Record review of Resident #28's order summary, dated 02/01/23, reflected: Lamictal Tablet 25 MG by mouth at bedtime for bipolar disorder. Record review of Resident #28's Pharmacist Recommendations, dated 10/16/23, reflected: Please ensure informed consent has been obtained and is available in the chart for the following orders: Lamictal - requires consent due to psych diagnosis of bipolar. (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: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/19/2024
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #28's electronic medical record on 01/18/24 reflected there was not a consent for Lamictal. An interview on 01/19/24 at 9:52 AM with Resident #28 revealed she was alert and oriented to person, place, and time. She said that she did not know she was taking Lamictal and did not realize the Lamictal was being used to treat bipolar disorder. She said she did not know she had bipolar disorder. An interview on 01/19/24 at 11:28 AM with ADON A revealed she was responsible for reviewing pharmacy recommendations. She said she must have overlooked the pharmacist recommendation to obtain consent for Lamictal for Resident #28. ADON A said there was a risk to the resident's rights if she was not informed about the medication, because she might not want to take the medication. An interview on 01/19/24 at 11:47 AM with the DON for Resident #28 revealed residents were supposed to give consent to receive medications and the ADONs were responsible for ensuring consents were obtained. Record review of the facility policy for Psychoactive Medications Consent, dated July 2014, reflected: .2. The use of psychoactive medication must first be explained to the resident, family member, or legal representative. A consent is to be obtained either from the resident or responsible party if resident unable to give. A verbal consent may be obtained if no responsible person is available. The person obtaining the consent is to sign the consent once obtained.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #68 and Resident #236) of twelve residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Residents # 68 and #236's rooms was in a position that was accessible to the residents. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #68 Review of Resident #68's Face Sheet dated 01/18/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included secondary Parkinsonism, (movement disorder that causes tremor, stiffness, or slowing of movement) and ataxic gait (unsteady and uncoordinated way of walking). Review of Resident #68's Quarterly MDS assessment dated [DATE] reflected resident was unable to complete the interview to determine the BIMS score. Resident #68 required supervision for bed mobility, walk in room, walk in corridor, dressing, toilet use, and personal hygiene. Review of Resident #68's Comprehensive Care Plan dated 01/03/2024 reflected resident was at risk for falls related to weakness, deconditioning, activity intolerance, unsteady gait/balance. One of the interventions was to be sure the call light was within reach and encourage the resident to use it for assistance. Observation on 01/17/2024 at 10:50 AM revealed Resident #68 was on his bed sleeping. Resident's call light was noted on the floor, behind the headboard, and with a box on top of the call light. Observation on 01/17/2024 at 10:54 AM revealed CNA S entered Resident #68's room and checked on Resident #68's roommate. CNA S went out of the room after checking on Resident #68's roommate. Observation and interview with CNA S on 01/17/2024 at 10:58 AM, CNA S said she did not notice Resident #68's call light was on the floor. CNA S said she thought the call light was with the resident. CNA S added she should had checked if the call light was within reach of the resident. CNA S pulled the call light from under the box the floor, cleaned it, and placed it near the resident. CNA S said the call light was important for the resident because it was how the resident could tell the staff that they needed help. CNA S added if the resident did not have their call lights, they might fall and be injured trying to stand up to get what they needed. CNA S said she would also check if the call lights of the other residents were within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #236 Review of Resident #236's Face Sheet dated 01/18/2024 reflected resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included osteoarthritis (a type of arthritis that happens when the cartilage that lines your joints is worn down and your bones rub against each other) of the right knee and idiopathic neuropathy (nerve pain). Review of Resident #236's Quarterly MDS assessment dated [DATE] reflected resident was unable to complete the interview to determine the BIMS score. Resident #236 was dependent on staff for personal hygiene, dressing, toileting, and transfer. Review of Resident #236's Comprehensive Care Plan dated 12/25/2023 reflected resident was at risk for falls related to muscle weakness and unsteady gait. One of the interventions was to be sure the call light was within reach and encourage the resident to use it to call for assistance. Review of Resident's #236's Fall Risk assessment dated [DATE] reflected resident had medium risk for fall. Observation and interview with Resident #236 on 01/17/2024 starting at 11:10 AM revealed Resident #236 was on her bed awake. The resident's call light was noted hanging on the headboard of the bed with the call light button and most of the call light cord at the back of the headboard. Resident #236 stated she did not know where her call light was. Observation and interview with ADON R on 01/17/2024 starting at 11:26 AM. ADON R said the call light should not be hanging on the headboard of the bed. ADON R said the call light was far from the resident and she could not reach it if she needed to call for assistance. ADON R pulled the call light and placed it where the resident could reach it. ADON R said it was important that the call lights were with the residents because it was their means of communication for their needs. ADON R said the resident might fall trying to get what they needed or even by just trying to get the call light to make somebody aware they needed something. ADON R added the expectation was the staff would make sure the call lights were with the residents when they leave the room. ADON R concluded she would in-service the staff about the importance of the call light for the residents and the call lights should always be within the reach of the residents. Interview with the DON on 01/19/2024 at 7:25 AM, the DON stated the call lights must be always within the reach of the residents. The DON said the residents used the call lights if they needed help or to alert the staff they were not feeling well. The DON added a lot of things could happen if the call lights were not with the residents. He continued the residents might try to get up on their own and fall on the process. The DON said the expectation was for the staff to make sure the call lights were within the reach of the residents. The DON said all the staff were responsible in placing the call lights within reach. The DON said he would make an audit of the call lights to make sure they were working and within the reach of the residents. Record review of facility's policy Accommodation of Needs Policy/Procedure rev. 08/2023 revealed Policy: it is the policy of this facility to assure that a resident . with reasonable accommodation of individual needs and preferences . Procedures . 6. Have the call light within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy Call Light/Bell Policy/Procedure - Nursing Clinical rev. 05/2007 revealed Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff . Procedures . 5. Leave the resident comfortable. Place the call device within reach before leaving the room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45055 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for areas in the facility for 11 (Resident #1, 14, 15, 23, 36, 48, 51, 52, 56, 70, and 80's) of 27 resident rooms observed for housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The facility failed to ensure that Resident #1, 14, 15, 23, 36, 48, 51, 52, 56, 70, and 80's rooms were cleaned, sanitized, and maintained. This deficient practice could place residents at risk of infections and living in an uncomfortable environment leading to a decreased quality of life. Findings included: Observation of Resident #1 and #56's room on 01/17/24 at 10:55 AM revealed the air-condition unit had black dirt stains on the top of the unit and in between the vents. The filter in the unit had a thick dust built-up. The inside main door had white and brown splash stains going down the door. In an interview on 01/17/24 at 10:57 AM with Resident #56, she stated her room had not been cleaned in at least a couple of days, and she stated that housekeeping never cleaned the air-condition unit and she had never observed them cleaning the air filters. She stated she had sinus and allergy problems and the lack of cleanliness of the unit did not help. Observation of Resident #48 and 52's room on 01/17/24 at 11:14 AM revealed the air-condition unit had black dirt stains on the top of the unit and in between the vents. The filter in the unit had a thick dust built-up. Observation of Resident #14 and 23's room on 01/17/24 at 11:19 AM revealed the minifridge in the room had a dark black stain on the outside of the lower bottom door. The inside of the freezer had a brownish stain on the lower shelf of the unit. Observation of Resident #15 and 80's room on 01/17/24 at 11:30 AM revealed the air-condition unit had dark dirt stains on the top of the unit and in between the vents. Resident #15's linen was heavily soiled with reddish stains near the headed the bed and in the middle and lower portion of the bed, the linen was dingy and had dark stains all over the linen. In an interview on 01/17/24 at 11:31 AM with Resident #15, he stated that the facility did not do a good job changing out his linen and they do not do a good job cleaning his sleep apnea machine. He stated his mother had complained to the DON about this before. Observation of Resident #70's room on 01/17/24 at 11:35 AM revealed the air-conditioned unit had dirt particles between the vents and both air filters were missing from unit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #36 and 51's room on 01/17/24 at 11:59 AM revealed the air-condition unit had dark dirt stains on the top of the unit and in between the vents. Resident #51's living area had over 50 opened sugar packets all over the floor. The wall near Resident #36's bed had a long thin brownish stain. In an interview on 01/19/24 at 02:00 PM with Housekeeping A, she stated had been at the facility for 4 months and she stated she was the housekeeper for Resident #1, 14, 15, 23, 36, 48, 51, 52, 56, 70, and 80's room. She stated they were trained to clean the room from top to bottom to include the walls, floors, refrigerators, bathrooms, the air-conditioned units, and change the linen. She stated the area identified in the observations may had been overlooked. She stated Resident # had an issue with hoarding things like sugar packets and they had a challenging time getting cleaning his area because he always got aggressive and fought with them. She stated anytime she tried to clean his area, she would have to get the nursing staff involved to distract him. She stated not cleaning the areas mentioned could result in an infection. In an interview on 01/19/24 at 02:17 PM with the Housekeeping Supervisor, he stated he had been at the facility almost 7 years. He stated he trained the new housekeeping staff by having them shadow a more experienced worker for three days, and then he placed them on a schedule for specific areas. He stated staff was supposed to clean the air condition filters, which he also serviced every three months. He stated housekeeping was responsible for general cleaning of the air condition unit. He stated housekeeping was supposed to clean the mini fridge in the room and they also threw away any food more than three days old. He stated he was familiar with Resident #51 room and he stated they had to get other nursing staff involved when cleaning his room. He stated he walked around and checked the rooms, especially when he does his Angel rounds, which was supposed to be done daily. He stated Angel rounds consisted of members of the Inter-disciplinary team being assigned rooms to observe daily. He stated they had to check for things like the resident's care and the condition of their environment. He stated if resident rooms are not thoroughly clean, it was an infection control concern. Review of the facility's policy on Environmental Services - Housekeeping (2022) revealed Housekeeping and Maintenance services include the cleaning, sanitization, and care for rooms and common areas of the facility to ensure that the facility is safe for all who reside, work, and visit.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interview and record review, the facility failed to make information on how to file a grievance or complaint available to the residents, including notifying residents individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing for 1 of (Resident #71) of 3 residents reviewed for grievances. 1. The facility failed to ensure Resident #71 knew how to file a grievance. The facility's failure could place the residents at risk for concerns not being reported and addressed. Findings included: Review of Resident #71's MDS assessment, dated 01/05/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her cognitive status was intact. Her diagnoses included stroke and diabetes. An interview on 01/18/24 at 10:55 AM with Resident #71 revealed she said staff had called her a liar. The resident said she did not file a grievance about the issue because she did not know how. Resident #71 said she wanted to file a grievance. An interview on 01/19/24 at 10:32 AM with the SW revealed she was responsible for making sure residents knew how to file a grievance. She said Resident #71 did not report any grievances to her. The SW said she completed quarterly assessments with the residents to make sure they knew how to file a grievance and she did not know why Resident #71 did not know how to file a grievance. She said it was important for residents to know how to file a grievance so that resident concerns could be addressed. An interview on 01/19/24 at 10:43 AM with the Operations Manger revealed he met with Resident #71 regarding her grievance. He said it was the SW's responsibility to ensure residents knew how to file a grievance. Review of the facility's policy and procedure, Grievances, not dated, reflected: .2. Residents and/or families are informed of and given a copy of the grievance policy during the admission process. General concerns may be voiced at Resident and/or Family Council meetings .

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F 0604

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45055

Based on observations and interviews, the facility failed to ensure the resident was free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 3 of 6 (Resident #14, #49, and #63) residents reviewed for restraints.

The facility failed to ensure Residents #14 and Resident #63 had physician orders or a physician assessment for a scoop mattress.

The facility failed to ensure Resident #49 had physician orders or a physician assessment for a large positioning wedge to be added to her bed.

These failures could unnecessarily inhibit the residents' freedom of movement or activity.

Findings included:

Resident #14

Record review of Resident #14's face sheet dated 01/18/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Relevant diagnosis included Quadriplegia (paralysis of lower extremities)

Record review of Resident #14's Quarterly MDS assessment dated [DATE] revealed the resident had a BIM score of 15 (cognitively intact). The resident was totally dependent upon the facility to assist with ADL care.

Record review of Resident #14's Comprehensive Care Plan dated 01/13/24 revealed the resident was care planned for having a history of falls, with an unwitnessed fall occurring as recently as 01/07/24. One of the interventions included 1/7/24 Scoop mattress in a place to assist resident in defining the edges.

Record review of Resident #14's Physician orders dated 01/18/24 revealed the resident had no active orders for a scoop mattress.

Record review of Resident #14's medical record from 02/21/23 to 01/18/24 revealed there was not a physician assessment for a scoop mattress.

In an observation on 01/17/24 at 11:21 AM of Resident #14 was observed to have a scoop mattress, which had raised edges.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 01/18/24 at 09:05 AM with LVN S, she stated that Resident #14 did have a scoop mattress she was unsure of when the resident was supplied the scoop mattress. She stated the resident did have a history of falls, but she was unsure of when the resident has his last fall. She stated she did not know if a physician assessment was completed, and she stated that she did not think physician orders were needed for a scoop mattress. She stated the risk of not completing an assessment to determine if the scoop mattress would pose a risk to the resident, could result in the resident harming himself. Resident #63 Record review of Resident #63's face sheet dated 01/18/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Relevant diagnosis included Alzheimer (mental function decline) Record review of Resident #63's Quarterly MDS assessment dated [DATE] revealed the resident had a BIM score of 99 (severe cognitive impairment). The resident was totally dependent upon the facility to provide ADL care. Record review of Resident #63's Comprehensive Care Plan dated 01/15/24 revealed the resident was care planned for having a history of falls, and one of the interventions included Bed in lowest position. dtr wants a scoop mattress if avail. Record review of Resident #63's Physician orders from 07/01/22 to 01/18/24 revealed there was not a physician assessment for a scoop mattress. In an observation on 01/17/24 at 11:29 AM Resident #63 was observed to have a scoop mattress, which had raised edges. Resident #49 Record review of Resident #49's face sheet dated 01/18/24 revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Relevant diagnosis included repeated falls, and abnormal posture. Record review of Resident #49's Quarterly MDS assessment dated [DATE] revealed the resident had a BIM score of 00 (severe cognitive impairment). The resident was totally dependent upon the facility to provide ADL care. Record review of Resident #49's Comprehensive Care Plan dated 12/15/23 revealed the resident was care planned for having a risk of pressure ulcers, and one of the interventions included assistance with turning and repositioning the resident to avoid pressure ulcers. Record review of Resident #49's Physician orders from 09/02/20 to 01/18/24 revealed there was not a physician assessment for a scoop mattress. In an observation on 01/17/24 at 11:32 AM Resident #49 was observed to have a positioning wedge on the left side of her body while she was laying on the bed. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 01/18/24 at 09:05 AM with LVN T, she stated that Resident #63 did have a scoop mattress and she thought that Hospice may had provided the mattress. She stated she was aware that the resident had falls but she was not sure how recently the last fall occurred, and she did not know when the resident first received the mattress. She stated she was unsure if there were physician orders, or an assessment completed prior to the mattress being installed. She stated she thought the resident's family member may had requested the scoop mattress after the resident's last fall. She stated the risk of the resident not having an assessment or physician order could result in the resident injuring herself. In an interview on 01/19/24 at 09:26 AM with ADON R, she stated she was the ADON for the long-term care unit and she was somewhat familiar with Resident #63, but she was unsure if she had a scoop mattress or not. She was advised that the resident was observed laying on a scoop mattress. She stated she was unsure if the resident had orders for the scoop mattress. She went and retrieved her laptop to check, and she stated she could not find any orders for the scoop mattress, but she did see in the resident's care plan where the family had requested a scoop mattress, so they did so at the family's request. She stated she did not think that orders were needed for the scoop mattress, so she did not understand the risk to the resident. She stated there was no assessment completed prior to the scoop mattress being provided to the resident. She stated she was new to the facility and was still learning the facility's process. In an interview on 01/19/24 at 09:59 AM with ADON H, she stated she was the ADON for Resident #14 and Resident #49. She stated both residents did require the equipment and it was care planned. She stated the residents did not have physician orders for the equipment and thought that if it was care planned, it was okay. She stated she thought assessments were done but was not sure. She stated the risk of an assessment not being done could result in the resident getting injured because the proper assessment was not completed. In an interview on 01/19/24 at 11:50 AM with the DON, he stated he did not think physician orders were needed for scoop mattresses or a positioning wedge. He stated he was made aware of the concerns regarding Resident #14 and#63 having scoop mattresses and Resident #49 having a positioning wedge. He stated they discuss adding these types of equipment usage during their Interdisciplinary Team meetings. He stated any assessments should be in the facility's system of records, but he was unsure if any of these residents had one on file. He stated the risk of the residents not having a proper assessment could result in the resident injuring themselves. Record review of facility policy on Restraint/Seclusion, revised March 30. 2022, revealed Chemical/Physical restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative, WITH THE EXCEPTION OF TEMPORARY BEHAVIORAL EMERGENCY.

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NAME OF PROVIDER OR SUPPLIER: Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Belt Line Road Garland, TX 75044	

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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** 37028 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #44) of three residents reviewed for care plans. The facility failed to ensure a fall mat was in place per the care plan for Resident #44. This failure could place residents at risk for not receiving care consistent with their care plan. Findings included: Review of Resident #44's MDS quarterly assessment dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Her cognitive status was severely impaired. Her diagnoses included stroke and non-Alzheimer's disease. There were no falls documented. Review of Resident #44's Care Plan dated 05/16/23, reflected the resident had falls related to poor balance, unsteady gait, and poor safety awareness. Interventions included low bed with fall mat. An observation and interview on 01/17/24 at 11:05 AM revealed Resident #44 was lying in bed. The bed was low, but there was no fall mat. The resident was pleasantly confused and would repeat questions instead of answering them. An interview on 01/19/24 at 10:05 AM with ADON R revealed Resident #44 was supposed to have a fall mat in her room. ADON R said the resident moved rooms and the fall mat was left behind in the other room. ADON R said the fall mat was needed to prevent injuries. An interview on 01/19/24 at 11:40 AM with the DON revealed Resident #44 had frequent falls. The DON said the resident was confused and would reach for something or stand to get out of her wheelchair and fall. The DON said the resident was supposed to have a fall mat on the floor by the bed. The DON said according to the care plan the resident was supposed to have a fall mat. She said Hospice provided a mat, but it was dirty, and the facility was going to order a new one. She said without a fall mat there was a risk that Resident #44 could have a fall with increase for severity of injury. Review of the facility's policy Care Plan Policy not dated, reflected: Purpose: To ensure resident service needs are met .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on interviews, and record review the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 3 residents (Residents #1, and #36) reviewed for ADLs care provided to dependent residents. The facility failed to ensure Resident #1, and #36 received showers consistently based on records reviewed for January 2024 and December 2023. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem. Findings Included: Resident #1 Record review of Resident #1's face sheet dated 01/18/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Relevant diagnosis included amputation below left and right knee. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed the resident had a BIM score of 14 (cognitively intact). The resident was totally dependent upon the facility to assist with ADL care. Record review of Resident #1's Comprehensive Care Plan dated 01/15/24 revealed the resident was care planned for having ADL self-care performance deficit and the goal for the resident was to maintain current levels function in bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene. Records review of Resident #1's Bath/Shower Sheets from 01/01/24 to 01/18/24, revealed the resident was scheduled to receive showers on Tuesdays, Thursdays, and Saturdays. The facility was only able to provide shower sheets for the following dates: 01/06/24: Bed bath 01/10/24: Bed bath 01/14/24: Bed bath In an interview on 01/17/24 at 10:55 AM with Resident #1, she stated she did not receive proper care at the facility and had not had a shower in nearly two weeks and they mainly only gave her bed baths. She stated she had not complained about this because she was scared of retaliation. (continued on next page)

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

In an interview on 01/19/24 at 01:11 PM with CNA C, she stated she had been at the facility for four years. She stated she was just filling in for the CNA that normally works the hall. She stated she asked the resident if she wanted showers the two days she worked, and Resident #1 had refused. She stated the first time she did not feel like it and yesterday she had refused and she think she told a nurse. She stated she documented in the PCC that the resident had refused a shower. She stated she thought she was to fill out shower sheet when showers are not given, but she was unsure. She stated that if the resident refused a shower, she notified the nurse. She stated she thought the nurse would go and speak with the resident to try to talk her into getting a shower. She stated she had told the nurse the nurse on Tuesday, 01/17/24, that the resident had refused her shower, but she was unsure if the nurse did anything. She stated if the resident was not getting her showers it could lead to infection and discomfort.

In an interview on 01/19/24 at 01:18 PM with LVN D, he stated he had been at the facility for nearly three weeks. He stated he was familiar with Resident #1 and usually worked her hall on Fridays. He stated he was not aware the resident was not receiving her showers, but he saw on her care plan to ensure that she received her showers. He stated there should not be any reason that she did not receive her showers. He stated he did not know her showers days and would have to look it up. He stated the CNAs are required to complete a shower sheet and then turn it into the nurses. He stated if the resident refuses the nurse attempts to persuade the resident and include family to intervene. He stated if residents did not receive her scheduled showers, she could have a skin breakdown.

In an interview on 01/19/24 at 02:09 PM with ADON R, she stated she was charge of the hall where Resident #1 resided. She stated the resident was scheduled to receive her showers on Tuesday, Thursdays, and Saturdays. She stated the resident did receive showers and often refuse showers. She stated the CNAs are supposed to complete shower sheets for all residents, whether they received a shower or refused one. She stated if a resident refused a shower, the CNA must notify their hall nurse and the nurse would then try to persuade the resident to take a shower and if the resident still refused, the nurse would notify family member and the resident's physician. She stated she is unsure why the resident had not been receiving her three showers a week. She stated the risk of the resident not getting her scheduled showers could result in skin breakdown.

Resident #36

Record review of Resident #36's face sheet dated 01/18/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Relevant diagnosis included acute chronic respiratory failure with hypoxia (heart and lung failure).

Record review of Resident #36's Quarterly MDS assessment dated [DATE] revealed the resident had a BIM score of 00 (severe cognitive impairment). The resident was totally dependent upon the facility to assist with ADL care.

Record review of Resident #36's Comprehensive Care Plan dated 12/20/23 revealed the resident was care planned for ADL care and was totally dependent upon the facility to assist with needs, including showers.

Record review of Resident #36's Physician Orders dated 01/18/24 revealed the resident had physician orders for Hospice care effective 12/18/23.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Records review of Resident #36's Bath/Shower Sheets from 01/01/24 to 01/18/24, revealed the resident was scheduled to receive showers on Tuesdays, Thursdays, and Saturdays. The facility was only able to provide shower sheets for the following dates: 01/02/24: Bed bath 01/03/24: Bed bath 01/08/24: Bed bath 01/10/24: Bed bath 01/12/24: Bed bath In an interview on 01/17/24 at 01:20 AM with Resident #36's family members stated they had been trying to get the resident a shower for the past two weeks and had been advised by Hospice that they had to special order a shower chair. They advised they would like for the resident to receive showers and not just bed baths. In an interview and observation on 01/18/24 at 09:05 AM with LVN S, she stated that Resident #36 received hospice services and the showers for the resident were completed by the Hospice Aide. She stated she was unsure why the resident was not receiving his showers when scheduled. She stated if the resident did not receive their scheduled showers, they could have skin breakdown. In an interview with Hospice Executive Director, she stated she was not familiar with Resident #36, but she has spoken with the RN and the aide that provided care to the resident. She stated the aide stated that the correct form was not being completed for the resident every time the aide was visiting the resident, but they had a meeting with the DON on 01/18/24 and was advised that there were no signed forms in the resident's binder. She stated she thought there was a breakdown in communication because the Resident's family members are not on the same page. She was advised that both family members were interviewed, and they had expressed concerns about the resident not receiving any showers and was told that they were waiting for a special chair. She stated she was not aware of any special chair being ordered. She stated she will follow up with the family and the facility. In an interview on 01/19/24 at 11:10 AM with ADON H, she stated that Resident #36 did receive Hospice care and he should have been receiving three showers a week, which was being provided by the Hospice Aide. She was advised that the family and hospice reported that no showers had been given to the resident since he had been at the facility. She stated she was unaware of this and would address the issue. She stated they had shower chairs at the facility, so she is unsure why the family was being told that a specific chair was being required because they had them. She stated the facility was overall responsible for ensuring Hospice care was being provided to the resident. She stated the risk of the resident not getting his showers could result in him developing wound and skin integrity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/19/24 at 11:50 AM with the DON, he stated Resident #36 received hospice care, but everyone should be involved in the care of the resident. He stated he met with the family weekly and with different family members. He stated he had advised the family member that the resident was a risk for falling out of the shower chair because he moved a lot, so they thought for the time being, a bed bath was the safest way. He stated they also had a shower bed, but the family member did not want to do that. He stated the risk of the resident not getting his shower when scheduled could result in skin breakdown. Record Review of facility policy on Showers, dated 05/2007, revealed It is the policy of the facility to promote cleanliness, stimulate circulation and assist in relaxation. Tasks commonly completed during the bathing process: o Inspect skin, especially those that are showing redness or signs of breakdown o Observe Range of Motion during the bathing process o If discomfort is present, ask the resident to describe and rate the discomfort o Record the procedure in the record

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review the facility failed to ensure residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for one (Resident #76) of one resident reviewed for gastrostomy tube management. The facility failed to ensure Resident #76 had an order for the enteral feeding (intake of food directly into the stomach) downtime. This failure could place residents at risk for underfeeding or overfeeding. Findings included: Review of Resident #76's Face Sheet dated 01/19/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included gastrostomy (medical procedure where a tube is inserted through the abdominal wall and into the stomach) status and dysphagia (swallowing difficulties). Review of Resident #76's Quarterly MDS assessment dated [DATE] reflected resident had moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment also indicated Resident #76 had a feeding tube while a resident of the facility. Review of Resident 76's Comprehensive Care Plan dated 01/18/2024 reflected resident had required tube feeding related to dysphagia following CVA (cerebrovascular accident or stroke) and one of the goals was the resident would maintain adequate nutrition and hydration status. Review of Resident #76's Physician Order dated 01/05/2024 reflected every shift Jevity 1.5 @ 75 ml/hr X 16 hrs, fluid flush 68 ml/hr X 16 hours. Observation and interview with LVN N on 01/18/2024 at 11:43, LVN N stated Resident #76 was not inside his room because he was in therapy. LVN N confirmed Resident #76 had a feeding tube and the order was to have it for 16 hours continuously. LVN N stated the downtime for Resident #76's tube feeding was 9am to 9pm. LVN N said she would check the order for the downtime. LVN N logged in to her computer and search for Resident #76's physician order. LVN N said there was no order for a downtime for Resident #76. LVN N added the order specified to administer the feeding formula for 16 hours but there was no mention about the downtime. LVN M said the risk for no order for downtime could be confusion because the nurses would not know when to stop the feeding and when to continue the feeding. She said another risk would be underfeeding, overfeeding, aspiration, and fluid overload. LVN N said she would clarify with MD what was the order for the downtime. Interview with LVN M on 01/18/2024 at 12:16 PM, LVN M stated she already spoke with NP about the enteral feeding downtime for Resident #76. LVN M said she received an order to add downtime of 9:00 AM to 5:00 PM. Review of Resident #76's new Physician Order dated 01/18/2024 reflected every shift Jevity 1.5 @ 75 ml/hr X 16 hrs, fluid flush 68 ml/hr X 16 hours. (Down Time: 9AM - 5PM). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #76's Progress Notes dated 12/19/2023 revealed RSDT (resident) family member . wants to know if RSDT's downtime could be around 0900 - 1000 related to . resident' s PT/OT session . Interview with DON on 01/19/2023 at 7:24 AM, The DON said the family requested not to have a downtime. The DON said there should be an order for the downtime so there would be consistency on when to stop the feeding and when to continue the feeding. He said without a clear order for the downtime, there could be confusion for the staff providing care for Resident #76. The DON said without the downtime, the resident could experience underfeeding, undernourishment, and overfeeding. The DON said he was responsible in monitoring if the resident with G-tube had a clear order for enteral feeding downtime. The DON said the expectation was the order should specifically say what time was the downtime. The DON said he would continually remind the staff to follow the order and procedure of tube feeding. Record review of facility's policy Gastrostomy Tube, Policy/Procedure - Nursing Clinical rev. 05/2007 revealed Policy: It is the policy of this facility to provide proper care . gastrostomy tubes. Record review of facility's policy Physician Orders, Policy/Procedure - Nursing Clinical rev. 01/2018 revealed Policy: It is the policy of this facility to accurately transcribe and implement orders . Procedure . 6. Medication, treatment, or related orders are transcribed . accurately and verified via the double check system process.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observation, interviews, and record reviews, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 4 (Resident #14, #15, #55, and #67) of 6 residents reviewed for respiratory care. The facility failed to ensure Resident #14's tubing on his Nebulizer machine was changed within the facility policy of 7 days. The Facility failed to ensure Resident #15's mask and tubing for his BiPAP machine was cleaned and sanitized. The facility failed to ensure Resident #55's nebulizer mask was properly stored and dated. The facility failed to ensure Resident #67's humidifier had water in it. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident #14 Record review of Resident #14's face sheet dated 01/18/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Relevant diagnoses included palpitations (irregular heartbeat), and bifascicular block (blockage in heart valve) Record review of Resident #14's Quarterly MDS assessment dated [DATE] revealed the resident had a BIM score of 15 (cognitively intact). The assessment also indicated the resident had an active diagnosis for palpitations and bifascicular block. Record review of Resident #14's Comprehensive Care Plan dated 12/05/23 revealed the resident was care planned for shortness of breath and an intervention included the use of a nebulizer machine. Record review of Resident #14's Physician orders dated 01/18/24 revealed the resident had an active order dated 01/11/2024 to Change Nebulizer Tubing/Mask/Mouthpiece every night shift every Wednesday. In an observation on 01/17/24 at 11:21 AM Resident #14's nebulizer machine reflected the tubing on the machine had no date of when the last change occurred. Resident #15 (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 #15's face sheet dated 01/18/24 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Relevant diagnoses included severe obesity, and Obstructive Sleep Apnea (airflow blockage while sleeping)

Record review of Resident #15's Quarterly MDS assessment dated [DATE] revealed the resident had a BIM score of 15 (cognitively intact). The assessment also indicated the resident had an active diagnosis for obstructive sleep apnea.

Record review of Resident #15's Comprehensive Care Plan dated 11/06/23 revealed the resident was care planned for difficulty breathing and obstructive sleep apnea.

Record review of Resident #15's Physician orders dated 01/18/24 revealed the resident had an active order dated 11/2/23 the following active physician order:

BiPAP at HS and PRN Setting IPAP AT 12, EPAP at 6 every evening and night shift. Remove in AM

Cleanse BiPAP Tubing and Mask every night shift, every Monday

In an observation on 01/17/24 at 11:29 AM, Resident #15's BiPAP machine reflected the mask and the tubing on the machine had no date of when the last cleaning occurred.

In an observation and interview on 01/18/24 at 09:05 AM with LVN S, she stated she was the day nurse for Resident #15. She stated the Resident did use a Sleep Apnea machine and she stated that the night nurse services the machine, which include cleaning the tubing and ensuring water was in the humidifier. She stated could tell of the machine had been serviced because it would have a date on around the tubing or mask. She looked for a date and could not find one. She stated she could not find a date and was not sure when was the last time it was serviced and had not checked. She stated the risk of the machine not being properly serviced could result in an infection.

In an interview on 01/18/24 at 09:10 AM with Resident #15's family member, she stated she just had a care plan meeting with the facility on 01/17/24 to discuss her concerns regarding the resident. She stated she had complained to the Administrator and the DON about his Sleep Apnea machine not being properly serviced. She stated she had concerns about the tubing and his mask not being cleaned at all and she had observed the humidifier empty, and they are not refilling it with distilled water.

In an interview on 01/19/24 at 09:59 AM with ADON H, she stated she was the ADON for Resident #14 and Resident #15. She was advised of Resident #14's Nebulizer tubing not being dated and of Resident #15's Sleep Apnea machine not being sanitized. She stated all tubing for respiratory machines are scheduled to be changed out on Wednesday nights by the night nurse and all the nursing staff should be checking for this on Thursday. She stated she thought that all of the Respiratory machines were serviced but they may had missed a few. She stated the risk of the tubing not being changed out could result in an infection. She stated Resident #15 eats a lot of food and used his sleep apnea machine a lot so it gets dirty faster. She stated they had increased his cleaning to be done daily when the machine is not in use. She stated not ensuring the resident mask and tubing are thoroughly clean could result in an infection control.

Resident #55

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of Resident #55's Face Sheet dated 01/18/2024 reflected the resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included mild intermittent asthma and anemia.

Review of Resident #55's Quarterly MDS assessment dated [DATE] reflected resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated Resident #55 had asthma as one of the primary medical conditions.

Review of Resident #55's Comprehensive Care Plan dated 12/07/2023 reflected resident had asthma and one of the interventions was give medications as ordered.

Review of Resident #55's Physician Order dated 11/16/2023 reflected Budesonide 0.5 MG/2ML Suspension. Give 3 ml by mouth two times a day for SOB. Give1 vial via nebulizer.

Observation and interview with Resident #55 on 01/17/2024 at 9:46 AM revealed Resident #55 was on her bed with family at bedside. Resident #55's nebulizer was noted sitting on top of the nebulizer machine. The part of the nebulizer mask that touches the face when in use was in contact with the top of the nebulizer machine. Resident #55 said she was on breathing treatment for the longest time because of her breathing problem. Resident #55 said the nurse would put a solution on the container connected to the mask, would turn it on, and put the mask on her. Resident #55 continued the nurse would go out of the room and would sometimes come back to take off the mask and put it on the table. Resident #55 said she was not sure if the nurse was putting it on a bag but she never saw a bag for her nebulizer. The resident said sometimes the nurse would not come back when it was done so she would put the mask on the table.

In an interview with RN P on 01/17/2024 at 9:56 AM, RN P said she was familiar with the care of Resident #55. She added Resident #55 had respiratory problems that was why she used a breathing treatment twice a day. RN P said the breathing mask should had been cleaned and bagged after every use to prevent respiratory issues. RN P continued the breathing mask was bagged to prevent contamination. She added the tubing and the mask should be dated to know when they were last changed and when they were supposed to be changed. RN P said she was not aware the mask for the breathing treatment was on the top of the nebulizer machine. She said she would get a new breathing mask and a plastic bag to store it.

In an interview with ADON R on 01/18/2024 at 10:29 AM, ADON R said it was not right that the breathing mask was just laying on top of the machine because the top of the breathing machine is not always clean. ADON R said it should not be on top of the nebulizer machine, said it should be bagged, and said it should be dated. ADON R said her expectation was staff would be vigilant in monitoring if the breathing apparatus because they use it to breath in. said this was an infection control issue because the resident might breathe in dirt acquired from the top of the nebulizer machine. ADON R said she would make sure the breathing mask would be changed, bagged, and dated. ADON R stated the nurses were responsible for ensuring the masks were bagged. She said the DON and ADONs were responsible in ensuring the nurses were doing the best practice regarding respiratory care. ADON R said she would do an in-service about respiratory care.

Resident #67

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Belt Line Road Garland, TX 75044	

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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	Review of Resident #67's Face Sheet dated 01/18/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included chronic respiratory failure with hypoxia and obstructive sleep apnea. Review of Resident #67's Quarterly MDS assessment dated [DATE] reflected resident had a moderate cognitive impairment with a BIMS score of 12. The Quarterly MDS Assessment indicated Resident #55 had asthma. Review of Resident #67's Comprehensive Care Plan dated 01/18/2024 reflected the resident had altered respiratory status related to chronic respiratory failure with hypoxia and one of the interventions was provide oxygen as ordered. Review of Resident #67's Physician Order reflected Change & Date All Oxygen Tubing, N/C, Mask, DuoNeb, Humidifier Bottles (If Needed & PRN Through Out Week; Also Remove Concentrator Filter to Clean Then Replace Once Completed. Every night shift every Wed for maintenance related to CHRONIC RESPIRATORY FAILURE WITH HYPOXIA. Observation and interview with Resident #67 on 01/18/2024 at 10:32 AM, Resident #67 was on his bed with supplemental oxygen via nasal cannula at 2 liters per minute. The nasal cannula was attached to the humidifier bottle of the oxygen concentrator. The humidifier bottle did not have water on it. Resident #67 said he was feeling just a faint flow of oxygen. Observation and interview with DON on 01/18/2024 at 10:37 AM, the DON went inside Resident #67's room when advised that the humidifier bottle did not have water in it. The DON stated he would get somebody to get some water for the humidifier. The DON said there should water on the humidifier to prevent nasal irritation. The DON said the purpose of the humidifier was to moisten the nasal linings and prevent dryness of the nose, throat, and lips. The DON said the staff should had make sure there was water on the humidifier. Observation and interview with ADON R on 01/18/2024 at 10:44 AM, ADON R entered Resident #67's room with a gallon of distilled water. ADON R detached the humidifier bottle and put some distilled water and attached the humidifier to the oxygen concentrator. ADON R stated the humidifier should had water on it to moisten the nose to prevent nasal dryness and irritation. ADON R said the staff should monitor if the humidifier had water on it. ADON R said she would in-service the staff about respiratory care. In an interview with the DON on 01/19/2024 at 7:25 AM, the DON stated they always make rounds in the morning to check on the rooms of the residents. The DON said the staff must had missed the breathing mask being not bagged and dated. The DON said if the nebulizer mask was just laying around, it could cause infection and the breathing could be compromised. The DON said it should be bagged to prevent the mask being dirty. The DON added it should be dated to monitor when it was last changed. The DON said the expectation was the staff would make sure the breathing apparatus being used were clean to prevent exacerbation of any respiratory issues. The DON said the expectation was the staff to monitor the breathing mask if bagged and dated. (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 facility's policy, Oxygen Administration, Policy/Procedure - Nursing Services rev. 07/2022 revealed POLICY: It is the policy of this facility that oxygen therapy is administered by licensed nurse as ordered by the physician . PURPOSE: The purpose of the oxygen therapy is to provide sufficient oxygen . will include: 1. That oxygen is to be administered; 2. When and how often oxygen is to be administered; 3. The type of oxygen device to use (i.e., mask, nasal).

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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** 47743 Based observation, interview, and record review, the facility failed to ensure that four (Resident #3, Resident #12, Resident #56, and Resident #58) of fifteen residents were provided medications and/or biologicals and pharmaceutical services to meet their needs. The facility failed to ensure CMA B and LVN N re-ordered medications on a timely manner for Resident #3 (Clopidogrel Bisulfate 75 mg), Resident #12 (Gabapentin capsule 100 mg), Resident #56 (Oxcarbazepine 300 mg) and Resident #58 (Levothyroxine Sodium 25 mcg). This failure could place the residents at risk of not receiving medications as ordered by the physician. Findings included: Resident # 3 Review of Resident #3's Face Sheet dated 01/19/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (insufficient oxygen in the brain causing stroke) affecting left non-dominant side and cerebral infarction due to thrombosis (formation of blood clot) of basilar artery (one of the arteries that supplies oxygen to the brain). Review of Resident #3's Quarterly MDS assessment dated [DATE] reflected resident was had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment also indicated cerebral infarction due to thrombosis as one of Resident #3's primary medical condition. Review of Resident #3's Physician Order for clopidogrel bisulfate oral tablet 75 mg dated 06/16/2023 reflected Give 1 tablet by mouth one time a day for CVA related to HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINANT SIDE; CEREBRAL INFARCTION DUE TO THROMBOSIS OF BASILAR ARTERY. Resident #12 Review of Resident #12's Face Sheet dated 01/19/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included low back pain and pain in right upper arm. Review of Resident #12's Quarterly MDS assessment dated [DATE] reflected resident had a severe impairment in cognition with a BIMS score of 05. The Quarterly MDS Assessment also indicated neuropathy as one of the additional active diagnosis. Review of Resident #12's Comprehensive Care Plan dated 12/26/2023 reflected resident had chronic pain related to osteoporosis and neuropathy (nerve pain) and one of the interventions was administer analgesia as per order. (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 Resident #12's Physician's Order for gabapentin capsule 100 mg dated 05/25/2023 reflected, Give 1 capsule by mouth one time a day for nerve pain. Resident #56 Review of Resident #56's Face Sheet dated 01/18/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included major depressive disorder and bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows). Review of Resident #56's Quarterly MDS assessment dated [DATE] reflected resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment also indicated bipolar disorder as one of Resident #56's primary medical condition. Review of Resident 56's Comprehensive Care Plan dated 12/03/2023 reflected resident had potential for mood problem related to bipolar and one of the interventions was administered medication as ordered. Review of Resident #76's Physician Order for Trileptal Tablet 300 mg (Oxcarbazepine) dated 12/29/2022 reflected Give 1 tablet by mouth three times a day for Bipolar d/o (disorder) related to BIPOLAR DISORDER, UNSPECIFIED. Resident #58 Review of Resident #58's Face Sheet dated 01/18/2024 reflected resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic (an illness persisting for a long time or constantly recurring) kidney disease and hypothyroidism (decreased production of thyroid hormones). Review of Resident #58's Quarterly MDS assessment dated [DATE] reflected resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment also indicated hypothyroidism as one of Resident #58's primary medical condition. Review of Resident 58's Comprehensive Care Plan dated 01/18/2024 reflected resident potential for complications related to dx of hypothyroidism and one of the interventions was give thyroid replacement therapy as ordered. Review of Resident #58's Physician Order for Levothyroxine Sodium Oral Tablet 25 MCG (Levothyroxine Sodium) dated 09/17/2023 reflected Give 1 tablet by mouth in the morning for hypothyroidism. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 01/18/2024 at starting at 7:44 AM revealed CMA B was preparing the medications of Resident #3. It was noted Resident #3's blister pack (a type of packaging in which a product is sealed in plastic, often with a cardboard backing) for clopidogrel bisulfate oral tablet 75 mg was completely out after CMA B put the last tablet in a small plastic cup. CMA B finished preparing the medications and gave the medications to Resident #3. After giving Resident #3's medication, she started to prepare Resident #12's medication. It was noted Resident #12's blister pack for gabapentin capsule 100 mg only had 3 capsules left. CMA B finished preparing the medications and gave the medications to Resident #12. After giving Resident #12's medication, CMA B started to prepare Resident #56's medication. Resident #56's blister pack for oxcarbazepine 300 mg only had one tablet. CMA B finished preparing the medications and gave the medications to Resident #56. CMA B said she was responsible in re-ordering medication that were running low. CMA B stated the medication should be re-ordered when the medication reached the blue portion of the blister pack. CMA C stated she did not notice the said blister packs were running low. CMA said sometimes she would wait until the medications were midway the blue portion of the blister pack before she would re-order. CMA B said some medications would be automatically re-ordered but said she still need to follow-up if the blister packs were not yet on the cart. CMA B said if medications were not re-ordered on a timely manner, the residents might run out of medications and their present medical situations might worsen. CMA B stated she would re-order the blister packs that were running low. Observation and interview with LVN N on 01/18/2024 starting at 3:21 PM revealed Resident #58's blister pack for levothyroxine 25 mcg only had two tablets. LVN N stated medications should be re-ordered as soon as medications reached the blue portion of the blister pack. LVN N said medications should not be re-ordered on the last minute because the residents will not have sufficient supply of medication in situations that the delivery was delayed. LVN N further added that this could worsen the residents' medical situation. LVN N said she should had checked the cart if there were medications that need to be re-ordered. LVN N said she would re-order Resident #58's medication. Interview with the DON on 01/19/2024 at 7:25 AM, the DON stated the staff must make sure the medications were re-ordered on a timely manner to make certain the residents have the medications they needed. It was not acceptable that residents did not have their medications because the medications were not re-ordered when it was supposed to be re-ordered. The DON said the staff should also follow-up with pharmacy why the needed medications were not yet in the facility. The DON said the expectation was all staff would follow the procedure in re-ordering medications so the residents would not run out of medications that was detrimental to their health. The DON concluded they would make an audit of the carts to see what medications needed re-ordering. Interview with ADON R on 01/19/2024 at 11:50 AM, ADON R stated it was not right that the medications were not re-ordered. ADON R said the nurses and the CMAs were responsible in re-ordering medications when the medications reached the dedicated area. ADON R stated that the medications should be re-ordered in a timely manner to make sure that the residents have enough supply of medications. ADON R said the facility had an e-kit (emergency kit) but the e-kit must be used for emergencies and not because the medications were not re-ordered. ADON R added the residents were taking those medications for a reason and if the residents would not be able to take those medications, it could cause adverse effects to the health of the residents. ADON R concluded she would in-service the staff to remind them the importance of re-ordering medications in a timely manner. (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 facility policy, Ordering and Receiving Medications FAC19 rev. 11.13.18 revealed Policy: Medications and related products are received . on a timely basis . Procedures . 2. Repeat medications . ordered as follows: . a. Re-order medications (seven) days in advance of need to assure an adequate supply is on hand.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45055 Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation. The facility failed to ensure food in the facility's refrigerator, was labeled and dated according to guidelines. The facility failed to ensure food in the freezer was not exposed from air-borne contaminants. The facility failed to ensure the ice machine, located in the facility's kitchen, was thoroughly cleaned. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings included: Observations on 01/19/24 from 09:17 AM to 09:21 AM in the facility's only kitchen revealed: o The ice machine, in the facility kitchen revealed the inside door hinges having rust on and inside the hinges. o One gallon container of dill pickle relish, located in the walk-in refrigerator, was dated 9-14 and there was no visible expiration date. o One large box of frozen chicken nuggets, located in the walk-in freezer, was not sealed and was exposed to air-borne contaminants. In an Interview on 01/18/24 at 11:10 AM with the Dietary Manager and Dietician, they stated they both managed the kitchen in the facility. They were both shown the ice machine and the rust along the door hinges, and she stated the cleaning of the ice machine was the responsibility of maintenance and they would notify the Maintenance Director. The Dietitian stated she had observed these concerns earlier in the day and had resolved the issues. She stated the kitchen staff had failed to date the item with the entire date and she discarded the food. The Dietician stated she had corrected the concerns by ensuring the bag of frozen chicken nuggets was sealed. They stated the risk of the concerns not being addressed could result in food-borne illnesses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/19/24 at 02:17 PM with the Housekeeping Supervisor, he stated that he was responsible for managing both housekeeping and maintenance responsibilities. He stated that maintenance was responsible for cleaning the ice machine in the kitchen. He stated they clean the inside of the ice machine thoroughly once a month with a cleaning agent. He was shown a picture of the inside door hinges having rust on and inside the hinges, and he stated he had observed this and was not sure how to remove it and would have to see if it could be cleaned or need to be replaced. He stated the risk of the concern not being addressed could result in contamination. Record Review of the Facility's policy on Food Storage and Supplies dated 2012, revealed All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. Air-tight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and date opened. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #43 and Resident #18) of 8 residents reviewed for infection. 1. The facility failed to ensure ADON R washed or sanitized her hands before putting on the resting hand splint to Resident 43's right hand. 2. The facility failed to ensure CNA C performed hand hygiene during incontinence care for Resident #18. Findings included: 1. Review of Resident #43's Face Sheet dated 01/19/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included cerebral infarction due to embolism of left middle cerebral artery and hemiplegia and hemiparesis following cerebral infarction. Review of Resident #43's Quarterly MDS assessment dated [DATE] reflected resident was cognitively intact with a BIMS score of 04. The Quarterly MDS Assessment also indicated resident had an impairment on one side of the upper extremity. Review of Resident 43's Comprehensive Care Plan dated 12/03/2023 reflected resident had no care plan for right resting hand splint. Review of Resident #43's Physician Order reflected Patient to don R resting hand splint with frequency from 2x to 5x a week with duration to pt's tolerance in order to manage contracture. Pt//therapy/nursing staff to remove splint as needed at any signs of redness/swelling/irritation. Observation and interview on 01/18/2024 at 10:46 AM revealed Resident #43 on his bed awake. A resting hand split was noted sitting on top of the right bedside table. When asked if he was supposed to wear the splints, Resident #43 nodded his head. Observation and interview with ADON R on 01/18/2024 starting at 10:52 AM, ADON R stated resident #43 did use a splint. ADON R said she would put the splint on if the resident would agree. ADON R asked the resident if he wanted the splint on. The resident nodded his head and made a thumb up. ADON R took the resting hand splint from the side table and started putting it on the resident. ADON R did not wash her hands before applying the splint. ADON R said she should have washed her hands before applying the splint. ADON R added it is important for the staff to wash their before providing care to prevent potential transfer of infection. ADON R said being busy was not an excuse not to wash the hands. ADON R said she should have stopped and think first of what should have been done. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 01/19/2024 at 7:26 AM. The DON stated handwashing was the best practice in the reduction of the transmission of infection. The DON said the staff must wash their hands before and after every care done. The DON said if the hands would not wash their hands, infection could spread from staff-to-staff, staff-to-resident, resident-to-resident, and resident-to-visitors. The DON said the expectation was for the staff to wash their hands before and after every care. The DON said he would start reminding the staff to always wash their hands before and after providing care or before and after doing a treatment for the residents. 2. Record review of Resident #18's Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia and chronic kidney disease. An observation on 01/17/24 at 10:59 AM of CNA C reflected she was preparing to perform incontinence care for Resident #18. The resident was incontinent of a large amount of loose stool. CNA C washed her hands and put on gloves. She folded down the front of the brief and cleansed the peri-area. The resident was turned to her right side and CNA C cleansed the resident's buttocks and removed the soiled brief. CNA C did not perform hand hygiene or change her gloves. CNA C reached into her shirt pocket and removed a package of cream. CNA C used the same soiled gloves to apply cream to the resident's buttocks and grabbed a clean brief. CNA C was stopped by the Surveyor and asked if she was going to perform hand hygiene and change her gloves. CNA C said she would after she finished providing care. The Surveyor asked CNA C if she had stool on her gloves. CNA C stopped, removed her gloves, and put on new gloves, but did not perform hand hygiene. CNA C changed the resident's clothes. An interview with CNA C on 01/17/24 at 11:10 AM revealed she was supposed to perform hand hygiene after changing her gloves, but instead she just changed her gloves. CNA C said she had been trained to perform hand hygiene and change her gloves and it was important to prevent the spread of infection. An interview on 01/17/24 at 1:35 PM with the DON for Resident #18 revealed staff were supposed to perform hand hygiene and change their gloves during incontinence care when going from clean to dirty. The DON said hand hygiene was important to prevent the spread of infection. Record review of facility's policy Hand Hygiene, Infection Prevention and Control Program revealed Policy: This facility considers hand hygiene the primary means to prevent the spread of infections . 4. Use .b, Before and after direct contact with residents.