STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676418	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Bulverde	384 Harmony Hills Spring Branch, TX 78070

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41651 Based on interview and record review, the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC) for 3 of 3 residents reviewed (Resident #235, Resident #236, and Resident #237) who received Medicare skilled services and were discharged with benefits remaining, in that: 1. Resident #235 was not given a NOMNC upon discharge from skilled services. 2. Resident #236 was not given a NOMNC upon discharge from skilled services. 3. Resident #237 was not given a NOMNC upon discharge from skilled services. This deficient practice could affect residents who were discharged from skilled services with benefits remaining by denying them the right of appeal. The findings were: 1. Record review of Resident #235's closed record revealed the resident was not given a NOMNC upon discharge from skilled services on 04/06/2024. 2. Record review of Resident #236's closed record revealed the resident was not given a NOMNC upon discharge from skilled services on 04/04/2024. 3. Record review of Resident #237's closed record revealed the resident was not given a NOMNC upon discharge from skilled services on 04/29/2024. Record review of the facility Beneficial Notice Worksheet revealed twenty-three residents had been discharged from a Medicare covered Part A stay with benefits remaining within the six months prior to the survey. During an interview with the BOM on 05/04/2024 at 2:49 p.m., the BOM stated that one of the twenty-three residents had been issued a NOMNC upon discharge because the facility did not issue NOMNCs when residents were returning home. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator on 05/04/2024 at 5:20 p.m., the Administrator confirmed that the facility did not issue NOMNCs to residents who planned to return home following a Medicare covered Part A stay with benefits remaining. The Administrator stated the facility did not have a policy regarding the issuance of NOMNCs.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to provide maintenance services necessary to maintain a comfortable interior for 1 of 8 Residents (Resident #182) who was observed for homelike environment. The facility failed to ensure Resident #182's bathroom was free of bad odors since admission. This deficient practice could affect any resident and contribute to feelings of hopelessness. The findings were: Review of Resident #182's face sheet, dated 5/3/24, revealed she was admitted to the facility on [DATE] with diagnoses including Depression Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Generalized Anxiety Disorder (condition with exaggerated tension, worrying, and nervousness about daily life events). Review of Resident #182's baseline Care Plan, dated 4/25/24 revealed she was a new admission and no cognitive impairment was noted. Review of Resident #182's progress note dated 5/2/24 revealed she discharged from the facility on this date. Observation and interview on 04/30/24 at 11:34 AM with Resident #182 revealed she was sitting in a chair in her room. She stated she arrived on Thursday, (4/25/24). She stated she had a really bad virus, was very weak and dehydrated. Resident #182 stated she was trying to get accustomed to the community and getting answers had not been easy. Observation and interview on 5/1/24 at 2:30 PM with Resident #182 revealed she was sitting in a chair in her room. Resident #182 had complained about not receiving a shower and then asked Surveyor BB to check the bathroom before leaving her room. Observation revealed a strong foul odor; it smelled like sulphur. Resident #182 stated she had told staff about the smell since she arrived. She stated the MS came in sometime this week and was in the bathroom but did not talk with her. Resident #182 stated the bathroom still smelled badly. Resident #182 commented, I don't know what's worse, not being able to shower or the smell in the bathroom. She stated she was not sure she wanted a shower at this point because of the smell. Interview on 5/1/24/24 at 4:20 PM with the MS revealed he encountered various rooms in the facility that had a strong sulphur smell coming from the plumbing lines since he started working, August 2023. He stated the p-traps (p-shaped bend pipe used in drainpipes to connect your sink's drain directly to the sewer system) would dry up i.e. shower drain, if not used; it would smell strongly of sulphur. He stated he called the plumbers in the past and they installed back flaps that kept the smell from surfacing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/2/24 at 2:20 PM with CNA A revealed there was a foul smell in Resident #182's bathroom. She stated she told one of the charge nurse's about it. CNA A stated she had worked at the facility for 5 and 1/2 years and it had been an on-going problem in the facility. Interview on 5/2/24 at 3 PM with the MS revealed staff reported last Wednesday (4/24/24) there was a strong, foul smell in the bathroom in the room Resident #182 was now occupying. He stated he ran water down the shower drain and the smell went away. On Tuesday (4/30/24) of this week he checked it again because staff told him it smelled badly in the shower. He stated he put enzymes down the shower drain. He further stated plumbers came in on 5/1/24 but did not have the size of black flaps they needed. They would be returning next week. Review of facility policy, Statement of Resident Rights', dated February 2017, read: Compliance Guideline: The community should educate, encourage, and honor the rights of those we serve. Further, the community should assist a resident/patient to fully exercise their rights as applicable. Resident/Patient Rights include: To safe, decent and clean conditions.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect for 2 of 27 Residents (Resident #185) whose records were reviewed for abuse and neglect. The ADM failed to report an allegation of injury of unknown origin after Resident #185 had an unwitnessed fall, on 4/21/24, resulting in a major head injury. These deficient practices could affect any resident and could contribute to further abuse and neglect. The findings were: Review of Resident #185's face sheet, dated 5/1/24, revealed she was admitted into the facility on [DATE] with diagnoses including Traumatic Suarachnoid Hemorrhage without loss of Consciousness, subsequent encounter and Unspecified Dementia (is a group of symptoms affecting memory, thinking and social abilities). Review of Resident #185's admission nursing assessment, dated 5/2/24, revealed Resident #185 was severely cognitively impaired and was incontinent of bowel and bladder. Review of Resident #185's Care Plan initiated 4/19/24 read have a Self Care deficit r/t weakness. Toileting/Incontinent Care by 1 person assistance and transfer: by 1 person assistance; more assistance at times / as needed only. Further review revealed an entry on 4/22/24 which read: am at risk for falls related to Actual Fall on 4/30/24, 4/29/24, 4/27/24, 4/21/24. Review of post-fall assessment, dated 4/21/24, revealed Resident #185 had a fall getting out of bed and sustained a laceration to the left side of the scalp. Resident #185 was unable to answer when asked about the fall due to confusion. Review of Resident #185's progress note, dated 4/21/24, revealed she returned from the hospital with sutures to the head. Observation and interview on 05/01/24 at 11:30 AM revealed Resident #185 lying in bed with 1/2 bed rail up on right side; close to the window and 1/4 side rail up on left side. Resident #185 was asleep. Interview with Resident #185's famiily member he did not see how Resident #185 fell , but stated she had multiple stitches on the left side of her head. The family member further stated Resident #185 was not oriented and had poor self-awareness. Interview on 5/2/24 at 4:20 PM with the ADM and DON revealed that Resident #185 fell on [DATE] and received sutures to the left side of her head. The ADM stated he was responsible for reporting incidents of unknown origin with major injury. He stated he believed a family member witnessed the fall. He asked to review the evidence and then would have a definitive answer. The ADM further stated he believed he should report it within 24 hours if it was a reportable event. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 5/2/24 at 6:30 PM with the ADM revealed there was not a witness involving Resident #185's fall on 4/21/24 and she was not able to tell staff what happened due to confusion. The ADM stated it was a reportable event and he should report it within 2 hours of the incident taking place. He stated he did not report the incident to HHSC and did not investigate it per facility policy. He further stated per policy it was important to report and investigate to ensure Resident #185 was not abused or neglected. Review of facility policy, Abuse Guidance: Preventing, Identifying and Reporting dated February 2017, read Prevention-The Administrator/Abuse Coordinator has the overall responsibility for the coordination and implementation of the ANE prevention and reporting program. Reporting Allegations or Suspicions of Abuse. Allegation of, incidents of or suspicions of abuse or neglect are reportable to state authorities in accordance with HHSC's PL 19-17. Report alleged or suspicions of abuse within the designated time frames in accordance with HHSC's PL 19-17; are reported immediately but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injuryfor 1 of 27 Residents (Resident #185) whose records were reviewed for abuse and neglect. The ADM failed to report an allegation regarding an injury of unknown origin, involving Resident #185 who had an unwitnessed fall on 4/21/24 resulting in a major head injury, within 2 hours per HHSC regulation This deficient practices could affect any resident and could contribute to further abuse and neglect. The findings were: Review of facility policy, Abuse Guidance: Preventing, Identifying and Reporting dated February 2017, read Investigative Procedures Related to Allegations of Abuse, Neglect or Exploitation. 1. The community should immediately take all appropriate steps to premeditate the non-compliance and protect the resident from additional abuse. The community should implement a response plan and take corrective action as appropriate. The response plan implemented should address the immediate risk, those identified at risk, systemic response to prevent abuse, neglect or exploitation from occurring in the future. 2. The community should investigate the reported abuse. A written report of the investigation submitted to HHSC no later than the fifth working day after the initial report. Review of Resident #185's face sheet, dated 5/1/24, revealed she was admitted into the facility on [DATE] with diagnoses including Traumatic Suarachnoid Hemorrhage without loss of Consciousness, subsequent encounter and Unspecified Dementia (is a group of symptoms affecting memory, thinking and social abilities). Review of Resident #185's admission nursing assessment, dated 5/2/24, revealed Resident #185 was severely cognitively impaired and was incontinent of bowel and bladder. Review of Resident #185's Care Plan initiated 4/19/24 read have a Self Care deficit r/t weakness. Toileting/Incontinent Care by 1 person assistance and transfer: by 1 person assistance; more assistance at times / as needed only. Further review revealed an entry on 4/22/24 which read: am at risk for falls related to Actual Fall on 4/30/24, 4/29/24, 4/27/24, 4/21/24. Review of post-fall assessment, dated 4/21/24, revealed Resident #185 had a fall getting out of bed and sustained a laceration to the left side of the scalp. Resident #185 was unable to answer when asked about the fall due to confusion. Review of Resident #185's progress note, dated 4/21/24, revealed she returned from the hospital with sutures to the head. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation and interview on 05/01/24 at 11:30 AM revealed Resident #185 lying in bed with 1/2 bed rail up on right side; close to the window and 1/4 side rail up on left side. Resident #185 was asleep. Interview with Resident #185's family member he did not see how Resident #185 fell , but stated she had multiple stitches on the left side of her head. The family member further stated Resident #185 was not oriented and had poor self-awareness. Interview on 5/2/24 at 4:20 PM with the ADM and DON revealed that Resident #185 fell on [DATE] and received sutures to the left side of her head. The ADM stated he was responsible for reporting and investigating incidents of unknown origin with major injury. He stated he believed a family member witnessed the fall. He asked to review the evidence and then would have a definitive answer. Interview on 5/2/24 at 6:30 PM with the ADM revealed there was not a witness involving Resident #185's fall on 4/21/24 and she was not able to tell staff what happened due to confusion. The ADM stated it was a reportable event. He should report it within 2 hours of the incident taking place and investigate the incident. He stated he did not report the incident to HHSC and did not investigate it per facility policy. He further stated per policy it was important to report and investigate to ensure Resident #185 was not abused or neglected.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to have physician for the resident's immediate care for 3 of 8 Residents (Resident #183 and Resident #185) whose records were reviewed for new orders. 1. Nursing staff failed to obtain an order to treat Resident #183's cradle cap upon admission, 4/10/24. 2. Nursing staff failed to obtain an order for the use of side rails for Resident #185 upon admission, 4/19/24. These deficient practices could affect any resident who was a new admission and could result in residents not receiving the treatment as needed or result in not obtaining physician orders for the use of equipment. The findings were: 1. Review of Resident #183's face sheet, dated 5/2/24, revealed he was admitted to the facility on [DATE] with diagnoses including Nonromantic intracranial hemorrhage (bleeding within your skull), Traumatic subarachnoid hemorrhage without loss of consciousness (is bleeding into the subarachnoid space-the area between the arachnoids membrane and the [NAME] mater surrounding the brain), Subsequent encounter Hydrocephalus (accumulation of cerebrospinal fluid (CSF) occurs within the brain. This typically causes increased pressure inside the skull), Unspecified. Review of Resident #183's nursing admission assessment dated [DATE] read Skin is intact no identified skin issues. Review of Resident #183's admission MDS assessment, dated 4/18/24 revealed his BIMS was severely cognitive impaired and was dependent on staff for all ADL's. Review of Resident #183's Care Plan initiated 4/24/24 read I have a Self Care. Bathing/Showering Care: by 1 person assistance. Observation and interview on 04/30/24 at 11:42 AM revealed Resident #183 was lying in bed; on an air mattress with both side rails up. Further observation revealed Resident #183 had extensive brownish colored flakes on the top of his head. A family member was visiting and expressed concern about Resident #183's about his hygiene. She looked at the top of his head and stated she had not noticed all the flakes. The family felt of it and stated it felt greasy. Observation on 5/4/24 at 3:18 PM with LVN L revealed she looked at Resident #183's scalp and stated it looked like Resident #183 had cradle cap. She reviewed Resident #183's physician orders and stated there was not an order for treatment for his condition. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. Review of Resident #185's face sheet, dated 5/1/24, revealed she was admitted into the facility on [DATE] with diagnoses including Traumatic Subarachnoid Hemorrhage without loss of Consciousness, subsequent encounter and Unspecified Dementia (is a group of symptoms affecting memory, thinking and social abilities). Observation and interview on 04/30/24 at 12:04 PM revealed 1/2 bed rail up on right side; close to the window and 1/4 side rail up on left side of the bed. Resident #185 was not in the room. Interview with the DON revealed Resident #185 was sent out to the hospital. Observation on 05/01/24 at 11:30 AM revealed Resident #185 lying in bed with 1/2 bed rail up on right side; close to the window and 1/4 side rail up on left side. Resident #185 was asleep. Review of Resident #185's bed rail assessment, dated 5/1/24, read Side rails are indicated and serve as an enabler to promote independence. Review of Resident #185's consolidated physician order's for May 2024 revealed there was not an order for the use of the side rails. Interview on 5/5/24 at 5:47 PM with the DON revealed any treatment or adaptive equipment used for a resident had to be on their physician orders. She stated it was important that nursing staff assess and obtain orders for residents so they would receive the necessary care as needed. Review of facility policy, Admission Orders, revised January 2024 read Compliance Guidelines: To ensure that the resident receives necessary care and services, a resident is not admitted to the community without physician orders that describe the resident's immediate care.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview an record review the facility failed to determine or should have determined, within 14 days, that there had been a significant change in the resident's physical or mental condition for 1 of 8 Residents (Resident #186) whose records were reviewed for assessments. MDS Staff failed to complete a significant change MDS assessment after Resident #186 returned from the hospital on 3/18/24, received a new diagnosis of Encephalopathy (a disease that affects brain structure or function. It causes altered mental state and confusion) and received new orders for his condition. This deficient practice could affect any resident who experienced a significant change and could result in residents not receiving the necessary care and services per MDS assessment. The findings were: Review of Resident #186's face sheet, dated 5/1/24, revealed he was originally admitted to the facility on [DATE] with diagnoses including Heart Failure (refers to the condition where the heart is unable to pump blood around the body properly and Acute Kidney Failure, (occurs when your kidneys suddenly become unable to filter waste products from your blood. When your kidneys lose their filtering ability, dangerous levels of wastes may accumulate, and your blood's chemical makeup may get out of balance) and then was readmitted from the hospital on 3/18/24. He was diagnosed with Hyponatremia (occurs when the concentration of sodium in your blood is abnormally low. Sodium is an electrolyte, and it helps regulate the amount of water that ' s in and around your cells), and Encephalopathy (damage or disease that affects the brain. It happens when there ' s been a change in the way your brain works or a change in your body that affects your brain. Those changes lead to an altered mental state, leaving you confused and not acting like you usually do. It is not a single disease but a group of disorders with several causes. It ' s a serious health problem that, without treatment, can cause temporary or permanent brain damage). Review for Resident #186's admission MDS assessment, dated 2/19/24 did not reveal a diagnosis of Encephalopathy. Review for Resident #186's 5 day MDS assessment, dated 3/21/24, revealed a diagnosis of Encephalopathy. Review of Resident #186's Care Plan revised on 5/1/24 revealed his family representative choose not to follow the physician's fluid restrictions. One of the interventions read: Provide education on options for care and reassure that choices will be respected. Review of physician orders for Resident #186's dated, May 2024, revealed an order for Sodium Chloride Tablet 1 GM Give 3 tablet by mouth one time a day for electrolyte supplement 3 tablets po daily to equal 3 gm po daily. Further review revealed Resident #186 was placed on a fluid restriction of 2000mL Qday on 3/19/24. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #186's Review of Resident #186's progress notes for March 2024 revealed on 3/12/24 revealed Resident #186 was transferred out to the hospital. He returned to the facility on [DATE]. Further review revealed on 3/28/24 Resident #186 was refusing to follow fluid restrictions. He was having daughter bring pedialyte (used for dehydration) for him to drink after going over his 2000mL Observation on 04/30/24 at 12:50 PM revealed Resident #186 lying in bed. He was not responsive during attempted interview. Interview on 05/05/24 at 04:34 PM Regional Nurse Consultant D and MDS Coordinator E, revealed they believed Resident #186 did not qualify for a significant change MDS assessment because the diagnosis of Encephalopathy would resolve. In reviewing the definition for significant change in the RAI Version 3.0 Manual RN Consultant D and MDS Coordinator E stated Resident #186 had experienced a significant change in his health condition; it did not resolve in 14 days and received clinical intervention. RN Consultant D and MDS Coordinator stated it was important they completed an assessment to ensure Resident #186 received all necessary services and care he needed. RN Consultant D stated they used RAI Version 3.0 Manual as their policy to complete resident assessments. Review of RAI Version 3.0 Manual dated October 2023 read: A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered [self-limiting], The resident's condition is not expected to return to baseline within two weeks.

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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** 27520 Based on observation, interview and record review the facility failed to provide necessary services to maintain good grooming, personal hygiene for residents who were unable to carry out activities of daily living for 3 of 8 Residents (Resident #182, Resident #183, and Resident #184) whose records were reviewed for grooming and personal hygiene. The facility failed to ensure: 1. Resident #182 received scheduled showers on 4/29/24 and on 5/1/24. 2. Resident #183's dirty t-shirt was changed out on 5/1/24. 3. Resident #184's face had not been shaved, his eyebrows and nose hair had not been trimmed since 4/30/24. These deficient practice could affect any resident and contribute to feelings of poor self-esteem and hopelessness. The findings were: 1. Review of Resident #182's face sheet, dated 5/3/24, revealed she was admitted to the facility on [DATE] with diagnoses including Depression Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Generalized Anxiety Disorder (condition with exaggerated tension, worrying, and nervousness about daily life events). Review of Resident #182's baseline Care Plan, dated 4/25/24 revealed she was a new admission and no cognitive impairment was noted. The Care Plan read: I may be at risk for: self-care deficit, falls, skin concerns, pain, infection & nutritional/hydration concerns and emotional distress. Goal: Resident's condition will be stable and his/her needs will be anticipated and met as indicated. Resident's emotional needs will be supported and resident will adjust to placement without any sign of emotional distress. Further review revealed Resident #182 preferred to be showered 2 to 3 times a week 2 or 3 days of the week; was ambulatory with use of a walker and required assistance by 1 person, more assistance at times / as needed only. Review of Resident #182's shower flow sheet for April/May 2024 revealed documentation showed Resident #182 received a shower on 4/26/24, 4/29/24 and on 5/1/24. Review of an OT treatment encounter note, dated 4/29/24, read Pt. completed self care tasks - oral care, facility hygiene, toileting; use of grab bars. (continued on next page)

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	676418	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Bulverde	384 Harmony Hills Spring Branch, TX 78070

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/30/24 at 11:34 AM with Resident #182 revealed she was sitting in a chair. She stated she arrived on Thursday, (4/25/24). She stated she had a really bad virus, was very weak and dehydrated. Resident #182 stated she was trying to get accustomed to the community and getting answers had not been easy. She stated she had a shower on Friday, (4/26/24), but did not get one yesterday, (4/29/24). She stated she was scheduled for a shower, tomorrow (5/1/24). Resident #182 stated I stink and can smell myself. She stated she had been wiping herself down. Resident #182 stated she had mentioned it to different staff but no one had returned to assist her. She stated she could probably shower on her own but staff did not want her showering without assistance. Observation and interview on 5/1/24 at 2:30 PM with Resident #182 revealed she was sitting in a chair in her room. She stated she still had not had a shower and at this point had given up asking staff for help. She asked that Surveyor BB go into the bathroom to check on it. Observation revealed a strong foul odor; it smelled like sulphur. Resident #182 stated she had also told staff about the smell since she arrived. She stated the MS came in sometime this week and was in the bathroom but did not talk with her. Resident #182 stated the bathroom still smelled badly. Resident #182 commented, I don't know what's worse, not being able to shower or the smell in the bathroom. She stated she was not sure she wanted a shower at this point because of the smell. Interview on 5/1/24/24 at 4:20 PM with the MS revealed he encountered various rooms in the facility that had a strong sulphur smell coming from the plumbing lines since he started working, August 2023. He stated the p-traps (p-shaped bend pipe used in drainpipes to connect the sink's drain directly to the sewer system) would dry up i.e. shower drain, if not used; it would smell strongly of sulphur. He stated it smelled of sulphur because the shower had not been used and the p-trap had dried out. Interview on 05/03/24 at 02:20 PM with CNA A revealed she and CNA B offered Resident #182 a shower on Monday, (4/29/24). Resident #182 stated the OT was going to help her with a shower on Tuesday, (4/30/24). CNA A stated the OT told them she showered Resident #182 on Tuesday (4/30/24). CNA A stated they did not shower Resident #182 on Wednesday because she had a shower on Tuesday and Resident #182 discharged yesterday, (5/2/24). Interview on 05/03/24 at 03:30 PM with the DOR revealed Resident #182 was on caseload from 4/26/24 to 430/24. She sated OT C was not working on this date. She reviewed OT C's progress note, dated 5/2/24, and it revealed OT C worked with Resident #182 on self-care tasks including upper/lower dressing, oral care, facial hygiene and toileting. The DOR stated those were all the care tasks documented. She further stated if OT C had helped with a shower she was required to document it. The DOR stated on 5/2/24 a Care Plan conference was held with Resident #182 and her family representative. Resident #182 opted to return home and was discharged by 12:30 PM, noon. 2. Review of Resident #183's face sheet, dated 5/2/24, revealed he was admitted to the facility on [DATE] with diagnoses including Nonromantic intracranial hemorrhage (bleeding within your skull), Traumatic subarachnoid hemorrhage without loss of consciousness (is bleeding into the subarachnoid space-the area between the arachnoids membrane and the [NAME] mater surrounding the brain), Subsequent encounter Hydrocephalus (accumulation of cerebrospinal fluid (CSF) occurs within the brain. This typically causes increased pressure inside the skull), Unspecified. Review of Resident #183's admission MDS assessment, dated 4/18/24 revealed his BIMS was severely cognitive impaired and was dependent on staff for all ADL's. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #183's Care Plan initiated 4/24/24 read I have a Self Care deficit r/t Stroke. I often drool and require a clothing protector. Dressing & Grooming: by 1 person assistance. Observation and interview on 05/01/24 at 11:02 AM revealed Resident #183 sitting in a high back wheelchair in the Bistro, common area. He was wearing a black t-shirt and the front of it was covered with white residue and drool. Interview with CNA A and CNA N revealed they got Resident #183 up and dressed him this morning. They stated family did his laundry and there were no clean shirts available this morning. CNA A stated she thought family would have been here already; she knew she could get a shirt from the lost and found stored in laundry. CNA A stated they were not able to put a clothing protector on because the ADM told them it was a dignity issue. CNA A and CNA N stated they would be upset if it was them or a family member sitting out in a common area with a dirty shirt on. They further stated they told the nurse about it. Interview on 05/01/24 at 4:30 PM with LVN O revealed CNA A and CNA N did not say anything to her about Resident #183 not having a clean shirt this morning. She stated the CNA's had the option to put a gown on him. LVN O stated she had not noticed Resident #183's t-shirt. 3. Review of Resident #184's face sheet, dated 5/1/24, revealed he was admitted to the facility on [DATE] with diagnosis including Alzheimer's Disease (brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition). Review of Resident #184's admission nursing assessment, dated 4/22/24 read: I have a Self Care deficit. Bathing/Shower Schedule: I prefer to be showered 2-3 times weekly 2 or 3 days of week. Dressing & Grooming: by 1 person assistance. Review of Resident #184's Care Plan, initiated on 4/30/24 read: I have a Self Care deficit r/t Cognitive Impairment, Poor physical functioning. It did not include interventions. Observation on 04/30/24 at 1:17 PM revealed Resident #184 lying in bed. He had stubbly facial hair, long and curly eyebrows and nose hair coming out of his nostrils. Interview with Resident #184 stated he was doing good and most staff was respectful. When asked about his facial hair, Resident #184 answered out of context. Resident #184 presented as alert with confusion. Observation and interviews on 05/05/24 at 3:35 PM revealed Resident #184 lying in bed. He had stubbly facial hair, long and curly eyebrows and nose hair trimming out of his nostrils. Interview with CNA G revealed Resident #184 was scheduled for a shower on 5/4/24 and the aide should have shaved him and trimmed his eyebrows and nose hairs. She stated that was part of what they did on shower days. Interview with LVN M revealed Resident #184 needed grooming and the aides should ensure he was clean and well groomed per his preference. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/05/24 at 5:47 PM with the DON revealed CNA's were responsible for showering residents per their schedule, for changing them, their overall hygiene if dependent and grooming residents on their showers days to include cutting their fingernails, shaving and trimming their eyebrows and nose hair as needed. She stated the aides had to document on the residents plan of care when they provided a shower and grooming. She stated she was familiar with Resident #184 and commented, He could use a shave when asked what she thought about his overall hygiene. The DON stated it was each residents right to be clean and well groomed. Review of facility policy, Routine Resident Care, dated 3/14/19, read: Residents should receive the necessary assistance to maintain good grooming and personal/oral hygiene. Guidelines: 1. Residents who are capable of performing their own personal care should be encouraged to do so either as independent or with set up by nursing team members. 2. Showers, tub baths, and/or shampoos should be scheduled at least twice weekly and more often as needed or per residents' preference.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers based on the comprehensive assessment for 1 of 3 Residents (Resident #183) whose record were reviewed for pressure ulcers. Nursing staff failed to apply a prevalon boot (designed with an open, floated-heel design which means the heel is completely floated. This provides continuous pressure relief) or offload Resident #183's left foot, on 4/30/24 and on 5/2/24, to prevent him from developing a pressure ulcer. This deficient practice could affect residents at risk for developing pressure ulcers and could contribute to developing avoidable pressure ulcers. The findings were: Review of Resident #183's face sheet, dated 5/2/24, revealed he was admitted to the facility on [DATE] with diagnoses including Nonromantic intracranial hemorrhage (bleeding within your skull), Traumatic subarachnoid hemorrhage without loss of consciousness (is bleeding into the subarachnoid space-the area between the arachnoids membrane and the [NAME] mater surrounding the brain), Subsequent encounter Hydrocephalus (accumulation of cerebrospinal fluid (CSF) occurs within the brain. This typically causes increased pressure inside the skull), Unspecified. Review of Resident #183's admission MDS assessment, dated 4/18/24 revealed his BIMS was severely cognitive impaired, was dependent on staff for all ADL's and was at risk for developing pressure ulcers. Review of Resident #183's Care Plan initiated 4/24/24 read My skin is fragile and I am at risk for skin injury--new or worsening skin condition. Turn, reposition frequently, float heels, as requested, and as tolerated. Review of Resident #183's wound assessment by wound specialist (outside contract provider), dated 4/25/24, revealed an assuasive device used was Pressure Relieving Boot. Recommendations included: Off-Load; Reposition per facility protocol ; Low Air Loss Mattress ; Dietician Consult. Observation on 04/30/24 at 11:42 AM revealed Resident #183 was lying in bed; on an air mattress with both side rails up. A family member was visiting and expressed concern that Resident #183 had developed pressure sores on his bottom. Further observation revealed Resident #183 did not have a prevalon boot or his feet were not being off-loaded. Interview on 5/2/24 at 9:26 AM with LVN /Treatment Nurse K revealed Resident #183 was at risk for skin break down because he was totally dependent and did not ambulate at all. He stated staff should be off-loading his heels to prevent pressure sores. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 5/4/24 at 3:15 PM revealed Resident #183 lying in bed with both side rails up. Further observation revealed his feet were not being off-loaded. Interview with LVN L revealed Resident #183's did not have a prevalon boot on his left foot per wound specialist recommendation for the prevention of pressure ulcers. She looked for the prevalon boot and could not find it. She stated staff could off-load his feet with pillows but there were no pillows being used to off-load his feet either. Interview on 5/5/24 at 5:47 PM with the DON revealed Resident #183 had a pressure sore on his buttock and was at risk for further breakdown. She stated a wound specialist was working with Resident #183 and recommended using a prevalon boot to prevent break down on his heels. The DON stated a family member would do Resident #183's laundry and stated she might have taken it to wash it. She sated staff should also be off-loading his heels with pillows to prevent pressure ulcers. Review of a facility policy, Pressure Ulcer Injury, revised January 2023, read Compliance Guidelines: Pressure Ulcer Injury. The community ensures that a resident who enters the community without pressure ulcers does not develop pressure sores unless the individual ' s clinical condition makes them unavoidable. A resident with pressure ulcer injury should receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. The community s skin program will include: X identifying the individual resident at risk for developing pressure ulcers; X identifying and evaluating the risk factors and changes in the resident s condition; X identifying and evaluating factors that can be removed or modified and implementing individualized interventions designed to stabilize, reduce, or remove underlying risk factors; X monitoring interventions and modifying the interventions as appropriate.

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 41937 Based on observations, interview, and record review the facility failed to ensure residents' environment remained as free of accidents and hazards as possible and each resident received adequate supervision and assistive devices to prevent accidents for 6 of 20 residents (#1, #3, #27, #39, #46 and #185) reviewed for assistance with safe mechanical lifts and falls. 1. On 05/05/2024 at 03:54 PM CNA R transferred Resident #39 from her bed to her wheelchair with the assistance of 1 person and caused Resident #39 discomfort and pain. 2. On 04/16/2024 The facility assessed 4 residents (#1, #3, #27, and #46) with the need for a mechanical lift and planned for residents to receive assistance with mechanical lifts with the aid of 1 person. 3. Resident #185 fell multiple times and on 4/21/24 sustained a laceration which required multiple sutures to the left side of her head. Staff failed to implement fall mats upon admission even though she was assessed to be a high fall risk and had a fall history prior to her admission and failed to ensure the mats were in place after implementing as a safety device. These deficient practices could place residents at risk for harm by not provideing sufficient staff to operate the lift and stabilize residents and by not implementing necessary assistive devices to help residents from sustaining injuries. The findings included: 1.A record review of Resident #39's admission record dated 05/04/2024, revealed an admitted [DATE] with diagnoses which included morbid obesity (a severe and complex disease involving having too much body fat, which increases the risk of many other health problems), anxiety disorder, abnormalities of gait and mobility, and spondylopathy (spinal arthritis). A record review of Resident #39's annual MDS assessment dated [DATE], revealed Resident #39 was a [AGE] year-old female admitted for long term care and assessed with medically complex diagnoses, adequate hearing, impaired vision without corrective lenses, clear speech with the ability to communicate and is usually understood and can understand others. Resident #39 was assessed with a BIMS score of 14 out of a possible 15 which indicated no cognitive impairment. Resident was assessed with a need for Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort with the following: Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Tub/shower transfer: The ability to get in and out of a tub/shower. Resident #39 was assessed as always incontinent with urine. A record review of Resident #39's weight assessment dated [DATE] revealed Resident #39 weighted 360 lbs. A record review of Resident #39's Nursing: Transfer / Lift Status, dated 04/10/2024, revealed RN Q assessed Resident #39 as needing total lift care and the intervention was Transfer: total lift x 1 team member. A record review of Resident #39's Nursing: Transfer / Lift Status dated 10/25/2022 revealed Resident #39 was assessed as requiring 2 staff for a mechanical lift related to Resident #39's inability to stand, pivot, and walk with limited or no physical assistance from staff and Resident #39's inability to bear weight on at least one leg; Total Lift Candidate While lifts are safe for one person transfer, physical limitations, medical conditions, behavioral factors, weight, girth, etc. of individual resident/patient, the number of team members required must be evaluated to perform safe patient transfers. b. Two Team Members. A record review of Resident #39's care plan dated 05/03/2024 revealed Resident #39 had a self-care deficit related to obesity, poor physical functioning, incontinence of bowel and bladder. Further review revealed Resident #39 was provided with interventions which included, TRANSFER: Total Lift x 1 Team Member, Date Initiated: 04/10/2024, Created on: 04/10/2024, Created by: (RN Q), ADNS (Assistant Director of Nursing Services). During an interview on 05/052024 at 01:20 PM Resident #39 stated she was unable to transfer out of bed by herself and needed assistance with a mechanical lift. Resident #39 stated she was accustomed to the staff to assist her with transferring out of bed with 2 staff but recently she had been transferred by 1 staff member. Resident #39 stated she was ok with the change if the staff was careful. During an interview on 05/05/2024 at 11:38 AM CNA R stated he was trained in mechanical lift safety and further stated the process required 2 persons to perform. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an observation on 05/05/2024 at 03:54 PM revealed Resident #39 was attended by CNA R and was transferred from her bed to her wheelchair. CNA R was unassisted by any other staff. CNA R asked Resident #39 to assist him by turning herself from her supine position to her left side and grabbing the left side 1/4 bed rail while he pulled on the transfer sheet from the right side of the bed. CNA R placed a mechanical sling underneath Resident #39's right side and asked Resident #39 to assist him by turning herself from her left side position to her right side and grabbing the right side 1/4 bed rail while he pulled on the transfer sheet from the left side of the bed. CNA R completed placing the mechanical lift sling underneath Resident #39 and proceeded to position the mechanical lift over her and connected the lift to the sling. CNA R proceeded to lift Resident #39 utilizing his right hand with the remote control of the mechanical lift while simultaneously guiding Resident #39 by manipulating the sling with his left hand. CNA R proceeded to manipulate the mechanical lift with his feet, and both hands and occasionally used his hands to stabilize Resident #39 when she began to slightly swing while suspended mid-air in the sling. While CNA R positioned the sling and mechanical lift behind Resident #39's wheelchair CNA R used his right hand to manipulate the mechanical lift and the remote control simultaneously and used his left hand to stabilize Resident #39 from swinging when Resident #39's bilateral toes rubbed against the center mast of the lift to which Resident #39 called out Oww! Watch my toes! CNA R released his right-hand grasp on the lift and stabilized Resident #39 with both hands while continuing to hold the remote control. CNA R continued to position the mechanical lift directly behind Resident #39's wheelchair and lifted Resident #39 higher than the back of the wheelchair and placed Resident up and over the back of the wheelchair to seat resident #39 in the wheelchair. Three attempts were made to lift Resident #39 and reseat her in the wheelchair due to her complaints that she said, I am slipping out .I am not comfortable During the multiple attempts CNA R continued to use his left hand to hold Resident #39's sling and his right hand to manipulate the remote control and the mechanical lift simultaneously. During an interview on 05/05/2024 at 04:30 PM Resident #39 stated she was transferred from her bed to her wheelchair by 1 staff, CNA R, and during the transfer she had discomfort when her toes bumped the mechanical lift, and was not seated well in her wheelchair, and felt anxiety related to fears of falling from the lift. During an interview on 05/05/2024 at 11:39 AM RN Q stated she assessed Resident #39 as a 1 person assist with the mechanical lift. RN Q was asked her rationale on how she came to the 1 person assist she stated she would refer to the DON for the response. 2. Resident #1: A record review of Resident #1's admission record dated 05/05/2024, revealed an admitted [DATE] with diagnoses which included morbid obesity (a severe and complex disease involving having too much body fat, which increases the risk of many other health problems), Vascular dementia (a group of symptoms affecting memory, thinking and social abilities), ankle and foot contractures, muscle wasting and atrophy. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #1's annual MDS assessment dated [DATE], revealed Resident #1 was an [AGE] year-old female admitted for long term care and assessed with medically complex diagnoses, adequate hearing, impaired vision with corrective lenses, unclear speech with the ability to communicate and is sometimes understood and can understand others. Resident #39 was assessed with a BIMS score of 01 out of a possible 15 which indicated severe cognitive impairment. Resident was assessed with a need for Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. with the following: o Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. o Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). o Tub/shower transfer: The ability to get in and out of a tub/shower. Resident #39 was assessed as always incontinent of bowel and bladder. A record review of Resident #1's Nursing: Transfer / Lift Status, dated 04/16/2024, revealed RN Q assessed Resident #1 as needing total lift care and the intervention was Transfer: total lift x 1 team member. A record review of Resident #1's care plan dated 05/05/2024 revealed Resident #1 had a self-care deficit related to cognitive impairment, limited physical functioning related to stiff or limited joint range of motion; poor physical functioning, weakness, and debility; incontinence of bowel and bladder with nursing interventions which included, Transfers: x 2-person assistance with Hoyer Lift Total Lift Sling Size: Large/green (175-300 pounds) Resident #3: A record review of Resident #3's admission record dated 05/05/2024, revealed an admitted [DATE] with diagnoses which included morbid obesity (a severe and complex disease involving having too much body fat, which increases the risk of many other health problems), muscular sclerosis (makes it difficult for the brain to send signals to rest of the body), and Parkinson's disease (symptoms of Parkinson's disease include difficulty walking, difficulty initiating movements, and a slow hand tremor). A record review of Resident #3's annual MDS assessment dated [DATE], revealed Resident #3 was an [AGE] year-old female admitted for long term care and assessed with medically complex diagnoses, adequate hearing, impaired vision with corrective lenses, clear speech with the ability to communicate and is usually understood and can understand others. Resident #39 was assessed with a BIMS score of 08 out of a possible 15 which indicated moderate cognitive impairment. Resident was assessed with a need for Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. with the following: o Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	o Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). o Tub/shower transfer: The ability to get in and out of a tub/shower. Resident #3 was assessed as always incontinent of bowel and bladder. A record review of Resident #3's Nursing: Transfer / Lift Status, dated 04/16/2024, revealed Resident #1 was assessed as needing total lift care and the intervention was Transfer: total lift x 1 team member. A record review of Resident #3's care plan dated 05/05/2024 revealed Resident #3 had a self-care deficit related to cognitive impairment, poor physical functioning, weakness and debility; incontinence of bowel and bladder, and Parkinson's disease with nursing interventions which included, Transfers: x 1-person assistance Resident: #27 A record review of Resident #27's admission record dated 05/05/2024, revealed an admitted [DATE] with diagnoses which included acquired absence of right leg below the knee, dementia (a group of symptoms affecting memory, thinking and social abilities), pressure ulcer of left heel and ankle, and muscle weakness. A record review of Resident #27's annual MDS assessment dated [DATE], revealed Resident #27 was a [AGE] year-old male admitted for long term care and assessed with medically complex diagnoses, adequate hearing, adequate vision without corrective lenses. Resident #27 was not assessed with a BIMS score because he was not understood. Resident was assessed with a need for Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. with the following: o Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. o Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). o Tub/shower transfer: The ability to get in and out of a tub/shower. Resident #3 was assessed as frequently incontinent of bowel. A record review of Resident #27's Nursing: Transfer / Lift Status, dated 04/16/2024, revealed Resident #1 was assessed as needing total lift care and the intervention was Transfer: total lift x 1 team member. (continued on next page)

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The Heights of Bulverde	384 Harmony Hills Spring Branch, TX 78070

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #27's care plan dated 05/05/2024 revealed Resident #27 had a self-care deficit related to disease process and management, debility and weakness with nursing interventions which included, TRANSFER: x 2-person assistance with Mechanical Lift Date Initiated: 01/25/2024 Created on: 01/25/2024 .TRANSFER: Total Lift Sling Size: Medium/Yellow (125-200 pounds) .TRANSFER: Total Lift x 2 Team Members Resident: #46 A record review of Resident #46's admission record dated 05/05/2024, revealed an admitted [DATE] with diagnoses which included palliative care (specialized medical care for people living with a serious illness, such as cancer or heart failure), end stage heart failure, and chronic pain. A record review of Resident #46's quarterly MDS assessment dated [DATE], revealed Resident #46 was an [AGE] year-old female admitted for long term care and assessed with medically complex diagnoses, adequate hearing, adequate vision without corrective lenses, clear speech with the ability to communicate and was usually understood and could understand others. Resident #46 was assessed with a BIMS score of 11 out of a possible 15 which indicated moderate cognitive impairment. Resident #46 was assessed with a need for Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. with the following: o Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). o Tub/shower transfer: The ability to get in and out of a tub/shower. Resident #46 was assessed as frequently incontinent of bowel and bladder. A record review of Resident #46's Nursing: Transfer / Lift Status, dated 04/16/2024, revealed the DON assessed Resident #46 as needing total lift care and the intervention was Transfer: total lift x 1 team member. A record review of Resident #46's care plan dated 05/05/2024 revealed Resident #46 had a self-care deficit related to chronic kidney disease, congestive heart failure, poor physical functioning, and weakness and disability with poor physical endurance with nursing interventions which included, Transfers: Hoyer lift transfer x 2-person assistance During a joint interview on 05/05/2024 at 07:20 PM the Administrator and the DON were asked for their rationale for utilizing 1 person assists with some residents who were assessed with a need for a mechanical lift stated, our company invested in technology (mechanical lifts) to benefit our patients and staff while maintaining safety as the biggest priority in conjunction with manufactures guidelines. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of the facility's mechanical lift manufactures website https://www.joerns.com/wp-content/uploads/2023/11/Hoyer_Family_Brochure4-6.pdf ; accessed 05/05/2024, titled Hoyer Family Brochure 4-6 revealed MOBILITY ASSESSMENT & LIFT SELECTION: This assessment is typically performed by a designated health professional or a team of health professionals. In addition, each patient will be assessed with regard to such factors as mental acuity, ability to comprehend instructions and cooperate in lifts and transfers, combativeness, weight, upper extremity strength, ability to bear weight, and specific medical conditions that may affect the selection of an appropriate means for lifting and transferring. Patient Classification: This coding is consistent with activities of daily living (ADL) Self-Performance Codes for a patient's performance over all shifts during the last seven days . DEPENDENT ANOTHER PERSON IS REQUIRED FOR EITHER SUPERVISION OR PHYSICAL ASSISTANCE IN ORDER FOR THE ACTIVITY TO BE PERFORMED - HELP NEEDED . 3 - EXTENSIVE ASSISTANCE (Functional Independence Measure 3) Can perform part of the activity, usually can follow simple directions, may require tactile cueing, can bear some weight, sit up with assistance, has some upper body strength, may be able to pivot transfer. Over the last seven-day period, help provided three or more times for weight-bearing transfers or may have required a total transfer. A record review of the facility's policy titled Safe Resident Handling / Transfers dated January 2023, revealed, Policy: it is the policy of this community to ensure that patients and residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the patient / resident while keeping the team members safe in accordance with current standards and guidelines . team members will perform mechanical lifts / transfers according to the manufacturer's instructions for use of the device 4. Review of Resident #185's face sheet, dated 5/1/24, revealed she was admitted into the facility on [DATE] with diagnoses including Traumatic Suarachnoid Hemorrhage without loss of Consciousness, subsequent encounter and Unspecified Dementia (is a group of symptoms affecting memory, thinking and social abilities). Review of Resident #185's admission nursing assessment, dated 4/19//24, revealed Resident #185 was severely cognitively impaired; was incontinent of bowel and bladder and she was a high risk for falling; had one or more falls between 3 and 12 months ago. Review of Resident #185's Care Plan initiated on 4/19/24 read have a Self Care deficit r/t weakness. Toileting/Incontinent Care by 1 person assistance and transfer: by 1 person assistance; more assistance at times / as needed only. Review revealed an entry on 4/22/24 which read: am at risk for falls related to Actual Fall on 4/30/24, 4/29/24, 4/27/24, 4/21/24. The approaches included: *Bed at appropriate height when unattended. Date Initiated: 04/22/2024; *Keep commonly used items close to resident for easy access. Date Initiated: 4/30/2024; Refer to therapy for screen and/or eval as indicated. Date Initiated: 04/27/2024; Assist resident to toilet before going to bed at night and/or naps during day. Date Initiated: 04/29/2024; Bed locked and in low position. Date Initiated: 04/30/2024; Bedside mat/mats as indicated. Date Initiated: 05/01/2024; Remind resident regularly to call for assistance in efforts to prevent falls. Initiated on: 04/30/2024; Routine rounds to help with safety checks by all team members. Date Initiated: 04/30/2024. Further review revealed on 4/30/24 Resident #185's Care Plan was updated with a new focused area My skin is fragile and I am at risk for skin injury--new or worsening skin condition. ACTUAL: LEFT ELBOW, TOP OF HEAD. Interventions included Apply treatment as ordered. Keep clean & dry and apply skin barrier cream as indicated. Therapeutic pressure reducing mattress. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of post-fall review SBAR, dated 4/21/24, revealed Resident #185 had a fall getting out of bed and sustained a laceration to the left side of the scalp. Resident #185 was unable to answer when asked about the fall due to confusion. Review of Resident #185's progress note, dated 4/21/24, revealed she returned from the hospital with sutures to the head. Review of post-fall review SBAR, dated 4/27/24 at 2 PM, revealed Resident #185 had an unwitnessed fall getting out of bed in her room. She sustained a skin tear. She did not complain of pain. Resident #185 was confused and unable to say what happened. Review of post-fall Review SBAR, dated 4/29/24 at 9:30 PM, revealed Resident #185 had an unwitnessed fall getting out of bed in her room. She stated she was going to the bathroom. There were no apparent injuries noted. Review of Resident #185's progress notes for April 2024 revealed on 4/21/24 she had a fall, on 4/22/24 she returned from the hospital with a new order, sutures to be removed in 7-10 days. placed on TAR. On 4/27/24 progress note read Resident had a fall incident at around 1600 noted on this shift. Had an abrasion on Lt/elbow. Vitals WNL On 4/29/24 the progress note read Called to pts room. CNA stated pt was on the floor. Found pt sitting on floor between R side of bed and window. sitting on her buttocks. Pt holding on to side rail. Pt stated, I was trying to go to the bathroom. On 4/30/24 the progress note read Wound Care nurse made SN saw resident was on the floor. resident was parallel to the bed. resident. Resident was noted with blood on her head. Resident was barefoot. Resident was incontinent to bowel. Resident call light was attached to bed. Resident was asked what occurred. Resident stated I don't know. I need to go to the restroom. Further review revealed RP requested for resident to be sent out to hospital. Patient returned from hospital visit at this time. No new orders at this time. Patient is in stable condition. Patient is also continuing to try to get up from bed on her own. Bed remains in lowest position at this time with call light within reach. Review of physician orders for May 2024 revealed the following orders: PT/OT/ST may evaluate and treat as needed, dated 4/19/2024. Sutures to top of Residents head, monitor for signs and symptoms of infection, every day shift for surgical, dated 04/25/2024 and initiated on 04/26/2024. Wound to left elbow, as needed for compromised dressing, dated 05/04/2024, initiated on 05/04/2024. Wound to left elbow, cleanse with wound cleanser or normal saline, pat dry, apply thermoform to wound bed and cover with dry dressing, every day shift every Mon, Wed, Fri for skin tear, dated 5/4/24 and initiated 5/6/24. Observation and interview on 05/01/24 at 11:30 AM revealed Resident #185 lying in bed with 1/2 bed rail up on right side; close to the window and 1/4 side rail up on left side. Resident #185 was asleep. Interview with Resident #185's family member revealed he did not see how Resident #185 fell , but stated she had multiple stitches on the left side of her head. The family member further stated Resident #185 was not oriented and had poor self-awareness. Observation on 5/2/24 at 6:32 PM revealed Resident #185 was trying to get out of bed. There were no staff on the hallway. Further observation revealed the floor mats on both sides of the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 5/2/24 at 6:35 PM at the nurse's station with LVN CC revealed there was a new order on this date for fall mats. Upon entering Resident #185's room, the Resident was lying in bed. LVN CC stated the bed was in the lowest position it would go. LVN CC stated Resident #185 was a high risk for falling because she often tries to get out of bed. He stated staff should making frequent rounds on the Resident. Observation on 5/4/24 at 3:25 PM revealed Resident #185 lying in bed wide awake. She stated she was doing fine and her head did not hurt. She felt of the left side of her head. Further observation revealed a meal tray on top of the bedside table by Resident #185's bed. The fall mat was propped on the wall. Observation and interview on 5/4/24 at 4:05 PM revealed Resident #185's meal tray was still on the bedside table by her bed. Interview with CNA DD revealed lunch was sent out really late today, about 2 PM. CNA DD stated Resident #185's family member asked they leave the lunch tray. She stated she checked in on Resident #185 about 45 minutes to an hour ago and did not notice the mat was not in place. She commented staff probably moved it when they delivered the lunch tray. CNA DD was noted to move the bedside table and placed the mat beside Resident #185's tray. CNA DD stated Resident #185 was a high risk fall and the mats should stay in place at all times as an intervention to try and keep the Resident from sustaining injuries if she fell . Interview on 5/5/24 at 5:47 PM with the DON revealed Resident #185 had a history of falling before her admission. She stated they did not implement fall mats right away because Resident #185 was ambulatory and believed the mats would be a safety hazard. She stated staff was to keep her bed in the lowest position, ensure the bed was locked at all times, take her to the bathroom after meals and therapy was working with her to improve bed mobility. The DON stated and staff was to make frequent rounds on her. The DON stated Resident #185 had fallen multiple times and had sustained a laceration to the left side of her head. She went out to the hospital and sustained multiple sutures as a result of the injury.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 41937 Based on observations, interviews, and record reviews the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 8 residents (Resident #183) reviewed for catheter care. CNA T lifted Resident #183's urine collection bag above the bladder during indwelling catheter care for Resident #183. This failure could place residents at risk for catheter associated urinary tract infections (CAUTI). The findings included: A record review of Resident #183's admission record dated 05/05/2024 revealed an admitted [DATE] with diagnoses which included retention of urine and urinary tract infection. A record review of Resident #183's admission MDS assessment dated [DATE] revealed Resident #183 was an [AGE] year-old male admitted for long term care with needs for an indwelling catheter care. A record review of Resident #183's physicians' orders revealed Resident #183 was prescribed an indwelling urinary catheter with catheter care on 04/15/2024 and on 05/01/2024 was prescribed an antibiotic for a urinary tract infection, ciprofloxacin. A record review of Resident #183's care plan dated 05/05/2024 revealed Resident #183 had a need for an indwelling foley catheter with nursing interventions which included providing care every shift and monitoring for infections. Further review revealed Resident #183 was at risk for infections and had a urinary tract infection. During an observation on 05/04/2024 at 03:40 PM CNA T and LVN S were observed providing Resident #183 indwelling urinary catheter care. Resident #183 presented supine in his bed while his indwelling urinary catheter was secured at his thigh and the urine collection bag was secures to the bedframe below the Resident's bladder. CNA T and LVN S continued to gather supplies, DON PPE, practiced hand hygiene and proceed to provide care at the bedside. While providing care and during repositioning Resident 183 CNA T manipulated the urine collection bag and raised it above Resident #183 body and bladder approximately 6 inches while moving it from 1 side of Resident #183's body to the other side. During a joint interview on 05/04/2024 at 04:52 PM LVN S and CNA T stated CNA T did raise the urine collection bag and tubing over Resident #183's body and bladder to reposition Resident #183. CNA T stated, I didn't raise the bag too high and when asked how high is too high? CNA T and LVN S responded with responses summarized as there was no other way to reposition Resident #183 other than to raise Resident #183 urine collection bag above the bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a joint interview on 05/05/2024 at 06:36 PM the Administrator and the DON stated their expectations for indwelling urinary catheter care was for staff to maintain the urinary collection bag below the level of the bladder and raising the bag above the bladder could cause urine backflow and urinary tract infections. A record review of the Centers for Disease and Controls website: https://www.cdc.gov/infectioncontrol/guidelines/cauti/index.html#anchor_1552413731 titled Catheter Associated Urinary Tract Infections CAUTI accessed 05/10/2024, revealed, .Proper Techniques for Urinary Catheter Maintenance .Keep the collecting bag below the level of the bladder at all times A record review of the facility's undated Indwelling Catheter Care (Daily Cleansing) revealed, objective: care and maintenance of indwelling catheters is essential to prevent infection and or complications. this clinical practice standard is written to clarify methods of daily cleansing care for residents with an indwelling catheter. while the CDC centers of Disease Control does not endorse routine meatal cleansing, this community does conduct daily and as needed end dwelling catheter cleansing Further review of the policy and attachments reveled no policy for maintaining the urine collection bag below the bladder level.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, interview and record review the facility failed to ensure its medication error rates were not 5% or greater. The facility had a medication error rate of 10%, based on 3 errors out of 30 opportunities which involved 2 of 8 residents (Resident #46 and #285) reviewed for medication administration and medication errors. 1. On 05/04/2024 at 07:31 AM LVN U failed to perform a safety check on the insulin injection pen prior to administering Resident #285's insulin injection. 2. On 05/04/2024 at 09:40 AM Medication Aide V administered Resident #46's antibiotic and nerve pain medication 40 minutes late. These deficient practices could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: A record review of Resident #285's admission record, dated 5/02/2024 revealed an admitted [DATE] with diagnoses which included type 2 diabetes, and neuropathy (the nerves that are located outside of the brain and spinal cord (peripheral nerves) are damaged.) A record review of Resident #285's admission MDS dated [DATE] revealed Resident #285 was a [AGE] year-old female admitted for long term care and was assessed with medically complex conditions which included diabetes with nerve damage. A record review of Resident #285's physician's orders dated 05/02/2024 revealed the physician prescribed Resident #285 was prescribed insulin glargine (a synthetic version of human used to control blood sugar levels) 100 units per milliliter, 25 units to be administered once a day at 08:00 AM subcutaneously (an injection below the skin). A record review of Resident #285's care plan dated 05/04/2024 revealed, I have diabetes and I am at risk for: Complications associated with diabetes: Frequent Infections, Diabetic wounds, Vision Impairment, Hyper\Hypo-Glycemia, Renal Failure, Cognitive\Physical Impairment With interventions which included, Administer my medications as recommended by my doctor, monitor labs as indicated During an observation and interview on 05/04/2024 at 07:31 AM revealed LVN U prepared Resident #285's insulin glargine injection pen and administered 14 units of insulin glargine to Resident #285 without first performing a safety check per the insulin glargine injection pens' manufacturer guidelines for safe injection administration. Continued observation revealed LVN U stated the injection pen was exhausted and needed to administer another 11 units to complete the 25 units prescribed. LVN U stated she was unaware of the manufactures' guidelines for performing a safety check prior to administering the insulin with the injection pen. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a joint interview on 05/05/2024 at 06:42 PM the Administrator and the DON stated nursing staff should follow insulin injection pen manufactures instructions to prime the injection pen prior to administration. A record review of the insulin glargine injection pen manufactures website, https://www.semglee.com/en/semglee-pen ; accessed 05/04/2024, Titled WHAT TO KNOW BEFORE USING THE PREFILLED PEN revealed, INSTRUCTIONS FOR USE (brand Name) (insulin glargine-yfgn) injection Single-Patient-Use Prefilled Pen injection . Follow these instructions completely each time you use (brand name insulin injection pen) to ensure that you get an accurate dose. If you do not follow these instructions, you may get too much or too little insulin, which may affect your blood glucose . Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly, removing air bubbles, Select a dose of 2 units by turning the white dose knob, Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it, Hold the pen with the needle pointing upwards, Tap the cartridge so that any air bubbles rise up towards the needle, Press the purple injection button all the way in, check if insulin comes out of the needle tip, you may have to perform the safety test several times before insulin is seen. If no insulin comes out, check for air bubbles, and repeat the safety test two more times to remove them. If still no insulin comes out, the needle may be blocked. Change the needle and try again. If no insulin comes out after changing the needle, your (brand name injection pen) may be damaged. Do not use this (brand name injection pen). A record review of Resident #46's admission record revealed an admitted [DATE] with diagnoses which included a history of urinary tract infections and myalgia (the medical term for muscle pain). A record review of Resident #46's annual MDS assessment dated [DATE], revealed Resident #27 was a [AGE] year-old male admitted for long term care and assessed with medically complex diagnoses. A record review of Resident #46's physician's orders dated 05/04/2024 revealed Resident #46 was prescribed ciprofloxacin 250mg once a day at 08:00 AM and gabapentin (a medication used for nerve pain) 300mg three times a day at 08:00, 02:00 PM, and 08:00 PM . A record review of Resident #46's care plan revealed Resident #46 had a focus for end-of-life care with nursing interventions which included, .Administer my medications and treatments as recommended by my doctor During an observation and interview on 05/04/2024 at 09:40 AM revealed Medication Aide V prepared and administered ciprofloxacin and gabapentin 40 minutes after the medications were ordered to be administered at 08:00 AM (professional standards account for medications to be administered 1 hour prior and up to 1 hour after the medications are scheduled). Medication Aide V stated she was late in administering the medications for residents this morning shift. Medication Aide V stated she had not reported the potentially late administrations to her supervisor the DON. During a joint interview with the Administrator and the DON stated, staff can accommodate residents needs and nursing staff stated residents wanted their medications after breakfast and Medication Aide V was following policy .time sensitive medications were medications with dosing more frequent than every 4 hours . per policy therefore, there was no risk to residents. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy request was made on 05/05/2024 for administration on injectable insulin and timely medication administration. As of 05/10/2024 these policies had not been provided. A record review of The Institute for Safe Medication Practices website, Guidelines for Timely Administration of Scheduled Medications (Acute) | Institute For Safe Medication Practices (ismp.org) , accessed 05/05/2024, titled, Guidelines for Timely Administration of Scheduled Medications revealed, .How to Use the Guidelines: These guidelines are applicable ONLY to scheduled medications (see definition section) . Definitions: 1. Scheduled medications include all maintenance doses administered according to a standard, repeated cycle of frequency (e.g., q4h, QID, TID, BID, daily, weekly, monthly, annually) . 2. Medications administered more frequently than daily but not more frequently than every 4 hours (e.g., BID, TID, q4h, q6h) Administer these medications within 1 hour before or after the scheduled time A record review of the National Library of Medicine's website, Nursing Rights of Medication Administration - StatPearls - NCBI Bookshelf (nih.gov) , accessed 05/05/2024 titled Nursing Rights of Medication Administration updated 09/04/2023, revealed, Definition/Introduction: Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration.[1] It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. These 'rights' came into being during an era in medicine in which the precedent was that an error committed by a provider was that provider's sole responsibility and patients did not have as much involvement in their own care.[2]; The five traditional rights in the traditional sequence include: . 'Right time' - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Bulverde	384 Harmony Hills Spring Branch, TX 78070

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to ensure residents were free from significant medication errors for 4 of 12 residents (Residents #13, #32, #33 and #285) reviewed for significant medication errors. 1. On 05/04/2024 at 07:31 AM LVN U failed to perform a safety check on the insulin injection pen prior to administering Resident #285's insulin injection. 2. On 05/04/2024 at 10:04 AM Medication Aide V administered oxcarbazepine (an anti-seizure medication), and Baclofen (an anti-muscle spasm medication) to Resident #13 late by 1 hr. and 5 minutes. 3. On 05/04/2024 at 10:09 AM Medication Aide V administered ferrous sulfide (an iron medication) and midodrine (a drug used to raise blood pressure) to Resident #32 late by 1 hr. and 9 minutes. 4. On 05/04/2024 at 10:18 AM Medication Aide V administered carbidopa-levodopa (a drug to treat Parkinson's disease) to Resident #33 late by 1 hr. and 18 minutes. These deficient practices placed residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: 1. A record review of Resident #285's admission record, dated 5/02/2024 revealed an admitted [DATE] with diagnoses which included type 2 diabetes, and neuropathy (the nerves that are located outside of the brain and spinal cord (peripheral nerves) are damaged.) A record review of Resident #285's admission MDS dated [DATE] revealed Resident #285 was a [AGE] year-old female admitted for long term care and was assessed with medically complex conditions which included diabetes with nerve damage. A record review of Resident #285's physician's orders dated 05/02/2024 revealed the physician prescribed Resident #285 was prescribed insulin glargine (a synthetic version of human used to control blood sugar levels) 100 units per milliliter, 25 units to be administered once a day at 08:00 AM subcutaneously (an injection below the skin). A record review of Resident #285's care plan dated 05/04/2024 revealed, I have diabetes and I am at risk for: Complications associated with diabetes: Frequent Infections, Diabetic wounds, Vision Impairment, Hyper\Hypo-Glycemia, Renal Failure, Cognitive\Physical Impairment With interventions which included, Administer my medications as recommended by my doctor, monitor labs as indicated (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 05/04/2024 at 07:31 AM revealed LVN U prepared Resident #285's insulin glargine injection pen and administered 14 units of insulin glargine to Resident #285 without first performing a safety check per the insulin glargine injection pens' manufacturer guidelines for safe injection administration. Continued observation revealed LVN U stated the injection pen was exhausted and needed to administer another 11 units to complete the 25 units prescribed. LVN U stated she was unaware of the manufactures' guidelines for performing a safety check prior to administering the insulin with the injection pen. During a joint interview on 05/05/2024 at 06:42 PM the Administrator and the DON stated nursing staff should follow insulin injection pen manufactures instructions to prime the injection pen prior to administration. A record review of the insulin glargine injection pen manufactures website, https://www.semglee.com/en/semglee-pen ; accessed 05/04/2024, Titled WHAT TO KNOW BEFORE USING THE PREFILLED PEN revealed, INSTRUCTIONS FOR USE (brand Name) (insulin glargine-yfgn) injection Single-Patient-Use Prefilled Pen injection . Follow these instructions completely each time you use (brand name insulin injection pen) to ensure that you get an accurate dose. If you do not follow these instructions, you may get too much or too little insulin, which may affect your blood glucose . Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by ensuring that pen and needle work properly, removing air bubbles, select a dose of 2 units by turning the white dose knob, take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it, Hold the pen with the needle pointing upwards, Tap the cartridge so that any air bubbles rise up towards the needle, Press the purple injection button all the way in, check if insulin comes out of the needle tip, you may have to perform the safety test several times before insulin is seen. If no insulin comes out, check for air bubbles, and repeat the safety test two more times to remove them. If still no insulin comes out, the needle may be blocked. Change the needle and try again. If no insulin comes out after changing the needle, your (brand name injection pen) may be damaged. Do not use this (brand name injection pen). A record review of Resident #46's admission record revealed an admitted [DATE] with diagnoses which included a history of urinary tract infections and myalgia (the medical term for muscle pain). A record review of Resident #46 annual MDS assessment dated [DATE], revealed Resident #27 was a [AGE] year-old male admitted for long term care and assessed with medically complex diagnoses. A record review of Resident #46's physician's orders dated 05/04/2024 revealed Resident #46 was prescribed ciprofloxacin 250mg once a day at 08:00 AM and gabapentin (a medication used for nerve pain) 300mg three times a day at 08:00, 02:00 PM, and 08:00 PM. A record review of Resident #46's care plan revealed Resident #46 had a focus for end-of-life care with nursing interventions which included, .Administer my medications and treatments as recommended by my doctor (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 05/04/2024 at 09:40 AM revealed Medication Aide V prepared and administered ciprofloxacin and gabapentin 40 minutes after the medications were ordered to be administered at 08:00 AM (professional standards account for medications to be administered 1 hour prior and up to 1 hour after the medications are scheduled). Medication Aide V stated she was late in administering the medications for residents this morning shift. Medication Aide V stated she had not reported the potentially late administrations to her supervisor the DON. During a joint interview with the Administrator and the DON stated, staff can accommodate residents needs and nursing staff stated residents wanted their medications after breakfast and Medication Aide V was following policy .time sensitive medications were medications with dosing more frequent than every 4 hours . per policy therefore, there was no risk to residents. A policy request was made on 05/05/2024 for administration on injectable insulin and timely medication administration. As of 05/10/2024 these policies had not been provided. 2., 3., and 4. During an observation and interview on 05/04/2024 at 09:33 AM revealed Medication Aide V at her duty station on the medication cart with the electronic medication record displayed revealed Residents #13, #32, and #33 were displayed in red. Medication Aide V stated the red highlighted residents indicated potentially late medication administrations. Medication Aide V stated she would be administering late medications due to her workload and residents wanted their medications after their breakfast. Medication Aide V stated she had not reported the Resident's preferences for medication administration to the physician. Medication Aide V stated she had not reported the potentially late medication administrations to her supervisor the DON. 2. A record review of Resident #13's admission record dated 05/04/2024, revealed diagnoses which included bipolar disorder (A serious mental illness characterized by extreme mood swings), migraine (a severe throbbing headache), spondylopathy (a form of arthritis that affect the spine and nearby joints). A record review of Resident #13's quarterly MDS assessment dated [DATE], revealed Resident #13 was a [AGE] year-old female admitted for long term care and assessed with medically complex conditions and a BIMS score of 15 out of 15 which indicated no cognitive impairment. A record review of Resident #13's physicians' orders dated 05/04/2024 revealed Resident #13 was prescribed oxcarbazepine 900mg two times a day at 08:00 AM and 08:00 PM, related to bipolar disorder and baclofen 5mg three times a day at 08:00 AM, 02:00 PM, and 08:00 PM. A record review of Resident #13's care plan dated 05/04/2024 revealed, Resident has a history of mental illness: Bipolar .Give medication as ordered . I am at risk for experiencing discomfort or pain related to: History of fractures., Immobility, Comorbid medical conditions, Chronic poor health . Administer my medication to relieve my pain as recommended by my doctor (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #13's Medication Administration Audit Report dated 05/04/2024 revealed Medication Aide V administered Resident #13's bipolar (oxcarbazepine) and muscle spasm (baclofen) medications at 10:05 AM 1 hour and 5 minutes late per professional standards of safe medication administration. 3. A record review of Resident #32's admission record dated 05/04/2023 revealed an admitted [DATE] with diagnoses which included anemia (low iron in the blood) and hypotension (low blood pressure). A record review of Resident #32's admission MDS assessment dated [DATE] revealed Resident #32 was an [AGE] year-old female admitted for long term care and assessed with medically complex conditions and a BIMS score of 15 out of 15 which indicated no cognitive impairment. A record review of Resident #32's physicians' orders dated 05/04/2024 revealed Resident #32 was prescribed ferrous sulfate 325mg three times a day, at 08:00 AM, 02:00 PM, and 08:00 PM, for Anemia; and Midodrine 10mg give three times a day, 08:00 AM, 02:00 PM, and at 08:00 PM, for Hypotension. A record review of Resident #32's care plan dated 05/04/2024 revealed, I am at risk for nutritional deficits and/or dehydration risks r/t Chronic comorbidity medical diagnosis, Dx: Heart disease, Thyroid disease, Dx: Diabetes, potential for constipation, anemia . Administer medications and supplements as ordered by my MD A record review of Resident #32's Medication Administration Audit Report dated 05/04/2024 revealed Medication Aide V administered Resident #32's iron supplement (ferrous sulfate) and low blood pressure (midodrine) medications at 10:09 AM 1 hour and 9 minutes late per professional standards of safe medication administration. 4. A record review of Resident #33's admission record dated 05/04/2023 revealed an admitted [DATE] with diagnoses which included Parkinson's disease (a motor syndrome that manifests as rigidity, and tremors). A record review of Resident #33's admission MDS assessment dated [DATE] revealed Resident #33 was a [AGE] year-old female admitted for long term care and assessed with medically complex conditions and a BIMS score of 15 out of 15 which indicated no cognitive impairment. A record review of Resident #33's physicians' orders dated 05/04/2024 revealed Resident #33 was prescribed Carbidopa-Levodopa Oral Tablet 25-100mg Give 2.5 tablet by mouth three times a day for Muscle Spasms give three times a day, 08:00 AM, 02:00 PM, and at 08:00 PM, for muscle spasms. A record review of Resident #33's care plan dated 05/04/2024 revealed, I have a Self-Care deficit related to Parkinson's and immobility . am at risk for experiencing discomfort or pain r/t Parkinson's and end of life care . Administer my medication to relieve my pain as recommended by my doctor (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #33's Medication Administration Audit Report dated 05/04/2024 revealed Medication Aide V administered Resident #33's Parkinson's disease (Carbidopa-Levodopa) medications at 10:18 AM 1 hour and 18 minutes late per professional standards of safe medication administration. During a joint interview with the Administrator and the DON stated, staff can accommodate residents needs and nursing staff stated residents wanted their medications after breakfast and Medication Aide V was following policy .time sensitive medications were medications with dosing more frequent than every 4 hours . per policy therefore, there was no risk to residents. A policy request was made on 05/05/2024 for administration on injectable insulin and timely medication administration. As of 05/10/2024 these policies had not been provided. A record review of The Institute for Safe Medication Practices website, Guidelines for Timely Administration of Scheduled Medications (Acute) | Institute For Safe Medication Practices (ismp.org) , accessed 05/05/2024, titled, Guidelines for Timely Administration of Scheduled Medications revealed, .How to Use the Guidelines: These guidelines are applicable ONLY to scheduled medications (see definition section) . Definitions: 1. Scheduled medications include all maintenance doses administered according to a standard, repeated cycle of frequency (e.g., q4h, QID, TID, BID, daily, weekly, monthly, annually) . 2. Medications administered more frequently than daily but not more frequently than every 4 hours (e.g., BID, TID, q4h, q6h) Administer these medications within 1 hour before or after the scheduled time A record review of the National Library of Medicine's website, Nursing Rights of Medication Administration - Stat Pearls - NCBI Bookshelf (nih.gov) , accessed 05/05/2024 titled Nursing Rights of Medication Administration updated 09/04/2023, revealed, Definition/Introduction: Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration.[1] It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. These 'rights' came into being during an era in medicine in which the precedent was that an error committed by a provider was that provider's sole responsibility and patients did not have as much involvement in their own care.[2]; The five traditional rights in the traditional sequence include: . 'Right time' - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys, for 1 of 4 medication carts reviewed for drug security and 1 of 8 residents (Resident #62) reviewed for medications at the bedside. 1. On 05/03/2024 LVN W was assigned the 100-hall nurse medication cart when at 08:16 AM he left the medication cart unattended and unlocked. 2. On 04/30/2024 at 11:42 AM Resident #62 had her medicated eye drops and medicated nasal spray unsecured at her bedside. This failure could place residents at risk for misappropriation of property and could place residents at risk for accidents and hazards. The findings included: 1. During an observation and interview on 05/03/2024 at 08:16 AM revealed the 100-hall nurses' medication cart unlocked and unattended by room [ROOM NUMBER], room [ROOM NUMBER] presented with the door closed. Observations of the 100-hall revealed staff and residents ambulating the hall. Continued observation revealed LVN W exited from room [ROOM NUMBER] to observe the medication cart unattended and unlocked. LVN W locked the medication cart and stated, I am sorry for leaving the medication cart unattended and unlocked. During a joint interview on 05/05/2024 at 06:30 PM the Administrator and the DON stated, (medication) carts unattended should be locked. A record review of Resident #62 admission records dated 04/30/2024 revealed an admitted [DATE] with diagnoses which included glaucoma of both eyes (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve) and seasonal allergies. A record review of Resident #62's annual MDS assessment dated [DATE] revealed Resident #62 was a [AGE] year-old female admitted for long term care and assessed with medically complex conditions. A record review of Resident #62's care plan dated 04/30/2024 revealed, I have seasonal allergies . Administer medication for allergies as ordered by MD . I have chronic health conditions & comorbid conditions that have affected my physical function and may further affect my quality of life. HTN (High Blood Pressure) HLD (Fatty Blood) Varicose veins overactive bladder Glaucoma . Administer my medications, treatments, respiratory treatments / therapy, and diet as recommend by physician. Provide care as tolerated and needed (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #62's physicians orders dated 04/30/2024 revealed Resident #62 was prescribed a medicated nasal spray, fluticasone Propionate Nasal Suspension 50mcg for allergies and eye drops for glaucoma, Lumigan Ophthalmic Solution (Bimatoprost). During an observation and interview on 04/30/2024 at 11:42 AM revealed Resident #62 at her bedside with a fluticasone nasal spray which she threw away in her trash can. Resident #62 stated it (the nasal spray) was empty. Continued observation revealed a small bottle of bimatoprost medicated eye drops on Resident #62 bedside table. Resident #62 stated she kept the eye drops at her bedside due to her lack of confidence the nursing staff could administer the eye drops on time and further stated she could go blind if she did not receive her eye drops. During a observation and interview on 04/30/24 at 01:27 PM CNA X stated she observed Resident #62 medicated eye drops at her bedside and Resident #62 medicated nasal spray in the trash can. CNA X stated she was not aware if Resident #62 could self-administer the medications and would report to LVN Y. During an observation and interview on 04/30/2024 at PM LVN S stated she observed Resident #62 medicated eye drops at her bedside and Resident #62 medicated nasal spray in the trash can. LVN S stated she was not aware of Resident #62 medications were stored at her bedside. LVN S stated staff needed to report medications not stored in the medication cart. During a joint interview on 05/05/2024 at 06:50 PM the Administrator and the DON stated, medication carts which were unattended should be locked .medications at resident's bedside should not be kept there without an assessment for safe self-administration and patient education to include monthly monitoring. A record review of the facility's policy titled Medication Cart Usage and Storage dated January 2023, revealed, Compliance Guidelines; the nursing team members nurses and medication aids use the medication card to systematically distribute physician ordered medications to residents . guidelines: 1. Security: the medication cart and its storage bins should be kept closed, secured and or in the line of sight when not in use. during administration of medications, the cart may be positioned in the doorway of the residence room with: drawers unlocked and facing inward, and within sight . return the medication containers to the proper drawer or bin in the medication cart

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 41937 Based on interview and record review revealed the facility failed to promptly notify the ordering physician, physician assistant, nurse practitioner or clinical nurse specialist that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for 2 of 8 Residents (Resident #9 and #30) whose records were reviewed for lab services. 1. The facility failed to report to Resident #9's physician and document abnormal laboratory results on 02/16/2024 and again on 03/01/2024, to include low abnormal sodium blood serum levels to the physician. 2. The facility failed to report to Resident #30's physician and document abnormal laboratory results on 03/02/2024. This deficient practice could affect any resident and contribute to resident's decline of health condition by not providing the physician information necessary to be informed decisions. The findings were: 1. Review of Resident #9's face sheet, dated 05/01/2024, revealed he was originally admitted to the facility on [DATE] with diagnoses including Heart Failure (refers to the condition where the heart is unable to pump blood around the body properly and Acute Kidney Failure, (occurs when your kidneys suddenly become unable to filter waste products from your blood. When your kidneys lose their filtering ability, dangerous levels of wastes may accumulate, and your blood's chemical makeup may get out of balance) and then was readmitted from the hospital on 03/18/2024. He was diagnosed with Hyponatremia (occurs when the concentration of sodium in your blood is abnormally low. Sodium is an electrolyte, and it helps regulate the amount of water that ' s in and around your cells), and Encephalopathy (damage or disease that affects the brain. It happens when there ' s been a change in the way your brain works or a change in your body that affects your brain. Those changes lead to an altered mental state, leaving you confused and not acting like you usually do. It is not a single disease but a group of disorders with several causes. It ' s a serious health problem that, without treatment, can cause temporary or permanent brain damage). Review for Resident #9's 5-day MDS assessment, dated 03/21/2024, revealed his BIMS was 7 out of 15 reflecting moderate cognitive impairment and a diagnosis of Encephalopathy. Review of Resident #9's Care Plan revised on 05/01/2024 read I have chronic health conditions & comorbid conditions that have affected my physical function and may further affect my quality of life. Labs as ordered & report abnormal findings to MD as indicated. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A record review of Resident #9's physicians orders dated 04/30/2024 revealed the physician ordered on 02/15/2024 lab tests for CBC (complete blood count), CMP (comprehensive metabolic panel), Hgb A1C (glycated hemoglobin). A record review of Resident #9's medical record revealed lab results dated 02/16/2024 with abnormal lab values which included: Sodium (salt abnormal levels may indicate a kidney problem or other disorder) 135; reference range 136-145; flag - low. Glucose (sugar abnormal levels may indicate diabetes) 111, reference range 74-109; flag - high. RBC (a blood test that measures how many red blood cells (RBCs) you have) 3.96; reference range 4.4-5.8; flag - low. HGB (Hemoglobin is a protein in your red blood cells that carries oxygen from your lungs to the rest of your body) 13.7; reference range 13.8-17.2; flag low. HCT (a blood test that measures how much of a person's blood is made up of red blood cells) 39; reference range 41-50; flag - low. HGBA1C (measures how much sugar is in the blood over the last 90 days) 6.1; reference range 4.5-5.7; flag - high. A record review of Resident #9's physicians orders dated 04/30/2024 revealed the physician ordered on 02/29/2024 lab tests for CBC (complete blood count), BMP (basic metabolic panel), lipid panel (measures fat in the blood), vitamin D, and CPK (CPK is an enzyme found mainly in the heart, brain, and skeletal muscle). A record review of Resident #9's medical record revealed lab results dated 02/16/2024 with abnormal lab values which included: Sodium (salt abnormal levels may indicate a kidney problem or other disorder) 132; reference range 136-145; flag - low. Glucose (sugar abnormal levels may indicate diabetes) 124, reference range 74-109; flag - high. Vitamin D 21; reference range 30-100; flag - low. RBC (a blood test that measures how many red blood cells (RBCs) you have) 3.4; reference range 4.4-5.8; flag - low. HGB (Hemoglobin is a protein in your red blood cells that carries oxygen from your lungs to the rest of your body) 11.7; reference range 13.8-17.2; flag low. HCT (a blood test that measures how much of a person's blood is made up of red blood cells) 36; reference range 41-50; flag - low. (continued on next page)

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	676418	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Bulverde	384 Harmony Hills Spring Branch, TX 78070

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A 6-month review, November 2023 through May 2024, record review of Resident #9's medical record revealed no evidence for documentation of abnormal lab reports to the physician. 2. Record review of Resident #30's admission record reveled an admitted [DATE] with diagnoses which included hyperkalemia (high potassium blood levels), vitamin D deficiency, and local infections of the skin. A record review of Resident #30's quarterly MDS assessment dated [DATE] revealed Resident #30 was a [AGE] year-old female admitted for long term care and assessed with medically complex conditions and a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. A record review of Resident #30's physicians orders dated 04/30/2024 revealed Resident #30 was ordered on 02/29/2024 a CBC TSH (complete blood count and thyroid stimulating hormone) blood lab test. A record review of Resident #30's abnormal lab results dated 03/02/2023 revealed the following abnormal results which included: HCT (a blood test that measures how much of a person's blood is made up of red blood cells) 48; reference range 35-46; flag - High. RDW (An RDW (red blood cell distribution width) blood test measures how varied your red blood cells are in size and volume) 15.7; reference range 11.5-14; flag High. MCHC (Mean corpuscular hemoglobin concentration (MCHC) measures the average hemoglobin concentration in a given volume of red blood cells) 29.6; reference range 32-36; flag - low. A 6-month review, November 2023 through May 2024, record review of Resident #9's medical record revealed no evidence for documentation of abnormal lab reports to the physician. Interview on 05/02/2024 at 04:04 PM with the ADM and DON revealed nursing staff should fax all lab results to the physician; call the physician, enter a progress note with new orders and enter the order into the consolidated orders. The DON stated nursing staff would write Review on the lab report only after receiving a verbal or written confirmation from the physician the fax was received and reviewed. She stated the ADON's would provide an update of all lab results, any concerns in the morning manager's meeting. Nursing staff should also contact the Residents' Representative with changes of the residents' condition/abnormal lab values and complete an SBAR for critical lab results. Review of facility policy , The community must provide or obtain ancillary services to meet the needs of its residents. The provision of ancillary services must be accurate and timely to ensure that testing for diagnosis, treatment, prevention, or assessment is maximized. Laboratory services: Services provided must be both accurate and timely. Timely means that laboratory tests are completed, and results are provided to the community (or resident's physician) within timeframe's normal for appropriate intervention.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on observation, interview, and record review, the facility failed to ensure that each resident receives, and the facility provides food that accommodates resident allergies, intolerances, and preferences for 1 (Resident #70) of 25 residents reviewed, in that: Resident #70 had an intense dislike of cheese and was served a cheese omelet for breakfast. This deficient practice could lead to diminished quality of life and weight loss. The findings were: Record review of Resident #70's face sheet, dated 05/05/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: UNSPECIFIED SEVERE PROTEIN-CALORIE MALNUTRITION, MUSCLE WASTING AND ATROPHY, and ANXIETY DISORDER. Record review of Resident #70's comprehensive MDS, dated [DATE], revealed a BIMS score of 11 which indicated moderate cognitive impairment. Record review of Resident #70's care plan, revised 04/08/2024, revealed a focus [Resident #70 is] at risk for nutritional deficits and/or dehydration risks r/t Chronic comorbidity medical diagnosis , Dx: Heart disease , Dx: Kidney disease / Renal failure, GI Disorder, mechanically altered diet, diagnosis of severe protein calorie malnutrition and interventions, Provide diet and fluids including supplements and snacks as ordered, Ask me or my representative what foods and drinks I prefer so that I will eat and drink adequately. Record review of Resident #70's meal ticket, dated 05/01/2024, for the breakfast meal revealed, Standing Orders: Dislikes: All Cheese, Milk (&Dairy). Observation on 05/01/2024 at 10:03 a.m. revealed Resident #70 had been served a cheese omelet. During an interview with Resident #70 at the same time as the observation, Resident #70 stated that he had an intense dislike of cheese and could not eat any foods with dairy, especially cheese, because they caused him to become nauseous. During an interview with the Registered Dietician on 05/01/2024 at 11:36 a.m., the Registered Dietician stated she gave the dietary staff an in-service regarding resident preferences and ensuring the meal tickets are checked as each meal is prepared. Record review of the facility policy, Dietary Services, revised January 2023, revealed, The community provides each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41651 FACILITY 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 facility kitchen reviewed, in that: 1. The walk-in freezer container approximately twenty-five boxes of frozen foods which were stored on the floor and haphazardly stacked on top of each other. 2. The reach-in refrigerator near the kitchen door contained a bottle of soda which belonged to a staff member. 3. The floor under the three-part sink in the dish room was soiled with a dark brown substance that appeared to be dirt or mud. 4. The walls throughout the kitchen were soiled with substances of various color. 5. The commercial toaster was soiled with an abundance of crumbs. 6. The microwave was soiled inside on all sides, the bottom, and the roof. 7. The fryer was soiled with an abundance of crumbs and the front and sides of the fryer were soiled with cooking oil. 8. The machines on either side of the fryer were soiled with an abundance of cooking oil. 9. The top and sides of the dish sanitation machine were soiled with a substance that appeared to be crystals and sand. 10. Boxes of frozen foods in the walk-in freezer were not sealed and frozen food items were exposed to freezer burn and contaminates. 11. Two dietary aides had facial hair and were not wearing moustache/beard nets. 12. The juice dispenser wand was soiled and leaking juice onto the floor. 13. The floor throughout the kitchen was soiled with substances of various color. 14. A tray with two bottles of jelly, a large container of peanut butter, and a knife soiled with peanut butter and jelly was left out overnight. These deficient practices could lead to illness due to foodborne pathogens. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The findings were: 1. Observation on 04/30/2024 at 9:50 a.m. revealed the walk-in freezer container approximately twenty-five boxes of frozen foods which were stored on the floor and haphazardly stacked on top of each other. During an interview with the Dietary Manager, at the same time as the observation, the Dietary Manager confirmed the walk-in freezer container approximately twenty-five boxes of frozen foods which were stored on the floor and haphazardly stacked on top of each other, confirmed the boxes should have been placed on the shelves, and stated the staff had not had time to properly store the frozen food items. 2. Observation on 04/30/2024 at 9:55 a.m. revealed the reach-in refrigerator near the kitchen door contained a bottle of soda which belonged to a staff member. During an interview with the Dietary Manager, at the same time as the observation, the Dietary Manager confirmed the reach-in refrigerator near the kitchen door contained a bottle of soda which belonged to a staff member and confirmed the personal drink should not have been in the refrigerator used to store food items for residents. 3. Observation on 05/01/2024 at 1:18 p.m. revealed the floor under the three-part sink in the dish room was soiled with a dark brown substance that appeared to be dirt or mud. During an interview with the Registered Dietician, at the same time as the observation, the Registered Dietician confirmed the floor under the three-part sink in the dish room was soiled with a dark brown substance that appeared to be dirt or mud and stated the floor was in such a state because the sink was becoming loose from the wall and We're waiting on Maintenance to fix the sink. During a subsequent observation on 05/03/2024 at 6:30 a.m., the floor under the three-part sink had been cleaned. During an interview with the Maintenance Director on 05/03/2024 at 4:23 p.m., the Maintenance Director stated he had no knowledge of the three-part sink coming lose from the wall. 4. Observation on 05/04/2024 at 9:36 a.m. revealed the walls throughout the kitchen were soiled with substances of various color. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed the walls throughout the kitchen were soiled with substances of various color and gave no explanation. 5. Observation on 05/04/2024 at 9:37 a.m. revealed the commercial toaster was soiled with an abundance of crumbs. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed the commercial toaster was soiled with an abundance of crumbs and gave no explanation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Observation on 05/04/2024 at 9:38 a.m. revealed the microwave was soiled inside on all sides, the bottom, and the roof. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed the microwave was soiled inside on all sides, the bottom, and the roof and gave no explanation. 7. Observation on 05/04/2024 at 9:39 a.m. the fryer was soiled with an abundance of crumbs and the front and sides of the fryer were soiled with cooking oil. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed the fryer was soiled with an abundance of crumbs and the front and sides of the fryer were soiled with cooking oil and gave no explanation. 8. Observation on 05/04/2024 at 9:39 a.m. the machines on either side of the fryer were soiled with an abundance of cooking oil. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed the machines on either side of the fryer were soiled with an abundance of cooking oil and gave no explanation. 9. Observation on 05/04/2024 at 9:40 a.m. the top and sides of the dish sanitation machine were soiled with a substance that appeared to be crystals and sand. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed the top and sides of the dish sanitation machine were soiled with a substance that appeared to be crystals and sand and stated the substance was residue from the cleaning fluid. 10. Observation on 05/04/2024 at 9:42 a.m. revealed boxes of frozen foods in the walk-in freezer were not sealed and frozen food items were exposed to freezer burn and contaminates. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed boxes of frozen foods in the walk-in freezer were not sealed and frozen food items were exposed to freezer burn and contaminates and gave no explanation. 11. Observation on 05/03/2024 at 6:30 a.m. revealed Dietary Aide Z and Dietary Aide AA had beards and moustaches and were not wearing moustache/beard nets while preparing the breakfast meal. During an interview with Dietary Aides Z and AA, at the same time as the observation, Dietary Aides Z and AA stated they had forgotten to don beard/moustache nets. Further observation at the same time revealed a third male dietary aide with a moustache and beard who was wearing the proper nets. 12. Observation on 05/04/2024 at 9:42 a.m. revealed the juice dispenser wand was soiled and leaking juice onto the floor. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed the juice dispenser wand was soiled and leaking juice onto the floor and gave no explanation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. Observation on 05/04/2024 at 9:43 a.m. revealed the floor throughout the kitchen was soiled with substances of various color. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed the floor throughout the kitchen was soiled with substances of various color and gave no explanation. 14. Observation on 05/04/2024 at 9:45 a.m. revealed a tray with two bottles of jelly, a large container of peanut butter, and a knife soiled with peanut butter and jelly was left out overnight. During an interview with the Dietary Manager on 05/04/2024 at 9:50 a.m., the Dietary Manager confirmed a tray with two bottles of jelly, a large container of peanut butter, and a knife soiled with peanut butter and jelly was left out overnight following snack preparation from the prior evening. Record review of the facility policy, General Kitchen Sanitation, revised October 1, 2018, revealed, The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition and Foodservice employees will maintain clean, sanitary kitchen facilities .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 41651 Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 (Resident #62) of 25 residents reviewed, in that: A bottle of prune juice which has been opened and was unrefrigerated, unlabeled, and undated was found on Resident #62's bedside table. This deficient practice could lead to illness due to foodborne pathogens. The findings were: Observation on 04/30/2024 at 11:42 a.m. of Resident #62's bedside table, revealed a bottle of prune juice which has been opened and was unrefrigerated, unlabeled with the resident's name, and undated. Further observation of the bottle revealed a manufacture's label which stated, Refrigerate after opening. During an interview with Resident #62, at the same time as the observation, Resident #62 stated that she drinks prune juice to alleviate constipation. The resident stated that her niece brings it to her and confirmed that she does not have a refrigerator and therefore, stores the prune juice on her bedside table. Record review of the facility policy, Dietary Services, revised January 2023, revealed, The community provides proper storage of foods provided by family members and others to ensure safe and sanitary storage, handling, and consumption.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 41651 Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 1 of 1 dumpster site reviewed, in that: The area near the facility's two dumpsters was soiled with spilled kitchen oil and other refuse. This deficient practice could lead to an unsanitary environment and encourage the presence of pests. The findings were: Observation on 05/03/2024 at 4:40 p.m., of the area near the facility's two dumpsters revealed two, forty-gallon drums were located behind the facility dumpsters. The lids of both drums were loose and used fryer oil had spilled from the drums onto the ground underneath, beside, and in front of the facility dumpsters. Further observation revealed a large kitchen cooking pot with no lid and full of used fryer oil was also located behind the dumpsters. Further observation revealed the presence of assorted bits of paper, cardboard, and other refuse on the ground in the dumpster area. During an interview with the Dietary Manager, at the same time as the observation, the Dietary Manager stated he was new in his position and did not know how to request that the used fryer oil be removed. The Dietary Manager confirmed that recent rain had caused the oil in the drums to overflow and spill around the dumpster area. The Dietary Manager stated the oil had not been removed since he had been Manager. Record review of the facility staff list, undated, revealed the Dietary Manager was hired on 06/27/2023. During an interview with the Maintenance Director, at the same time as the observation, the Maintenance Director confirmed the spilled oil could present a slip and fall hazard for facility staff, or a fire hazard. Record review of the facility policy, Garbage Receptacles, revised June 1, 2019, revealed, The facility will maintain garbage receptacles in a clean and sanitary manner .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41651 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for 1 of 1 facility kitchen reviewed, in that: Flies too numerous to count were observed in and around the food preparation area. This deficient practice could affect residents, staff, and visitors who consume foods prepared in the facility kitchen. The findings were: Observation on 05/01/2024 at 1:20 p.m. revealed flies too numerous to count in and around the food preparation area in the facility kitchen, and especially concentrated near a box of fresh bananas. During an interview with Dietary Aide Y, at the same time as the observation, Dietary Aide Y stated, There are always flies all over the place in here [the facility kitchen]. Record review of the pest control visit logs revealed the pest control company visited bimonthly. Record review of the facility policy and procedure, titled Pest Control, effective date February 2017, revealed: 1. The community maintains an effective pest control program so that the community is free of pests and rodents. An effective Pest Control Program is defined as measures to eradicate and contain common household pests (e.g., roaches, ants, mosquitoes, flies, mice, and rats).