STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676438	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Killeen Nursing & Rehabilitation	5000 Thayer Dr Killeen, TX 76549

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation, interview and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of each resident's needs for 5 of 15 residents (Residents #54, #24, #52, #81 and #69) reviewed for call lights. Residents #54, #24, #52, #81 and #69 were observed in their rooms with their call lights not in reach. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident #54's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] for respite care with diagnoses of Unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and Unspecified combined systolic and diastolic congestive heart failure (left and right ventricles of heart are not functioning properly. Blood may back up into the lungs and or the body tissues leading to shortness of breath, fatigue, swelling in the legs and abdomen, and decreased exercise tolerance). Record review of Resident # 54's MDS assessment dated [DATE] reflected she was totally dependent on staff for moving in the bed and sitting up on the side of the bed. Record review of Resident #54's Care Plan dated 02/14/2024 reflected it did not address her call light placement. Observation on 02/20/2024 at 7:13 AM in Resident #54's room revealed she was in her bed and her call light was on the floor and out of her reach. Record review of Resident #24's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of cellulitis (bacterial skin infection that affects the deeper layers of skin) of left lower limb, muscle wasting and atrophy (loss of muscle mass and strength), Difficulty in walking, unsteadiness on feet, and acute osteomyelitis (painful bone infection caused by bacteria) left ankle and foot. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's Comprehensive MDS assessment dated [DATE] reflected he required substantial/maximal assistance for chair/bed to chair transfer. Record review of Resident #24's Care Plan dated 02/20/2024 reflected he had a wound vac (a device used to drain excess fluid, reduce bacteria in the wound and help draw together wound edges) to his left lateral foot. Observation on 02/20/2024 at 7:25 AM in Resident # 24's room revealed he was in his bed with a wound vac attached to his left foot wound. His call light was on the floor and was not in reach. Record review of Resident #52's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of legal blindness, need for assistance with personal care, difficulty in walking and muscle weakness. Record review of Resident #52's Quarterly MDS assessment dated [DATE] reflected she was able to transfer on her own. Record review of Resident #52's Care Plan dated 09/22/2023 reflected she was at risk for falls related to hypoglycemia (low amount of sugar in the blood). Approach: Place resident in a fall prevention program. Observation and interview on 02/20/2024 at 8:35 AM revealed Resident #52 was in her bed and her call light was on the floor. She stated she did not know where her call light was located. A white cane typically used by individuals who are blind was by the exit door of her room. Record review of Resident #81's undated Face Sheet reflected he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of pressure ulcer of sacral region (bedsore in area around the lower back and upper buttocks), and abnormalities of gait and mobility. Record review of Resident #81's Comprehensive MDS assessment dated [DATE] reflected he was dependent for indoor mobility and used a manual wheelchair. Record review of Resident #81's Care Plan dated 11/12/2023 reflected he had a history of falls related to rolling out of bed. Approach: Give resident verbal reminders not to ambulate/transfer without assistance. Place resident in a fall prevention program. Observation on 02/20/2024 at 10:00 AM revealed Resident #81 was in his bed and his call light was located under his bed and out of reach. Record review of Resident #69's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Abscess of bursa (localized collection of pus in bursa, a small fluid filled sac located near joints that acts as a cushion between bones, tendons, and muscles) right hip, Muscle wasting and atrophy, unsteadiness on feet, Record review of Resident #69's Quarterly MDS assessment dated [DATE] reflected he required substantial/maximal assistance for chair/bed to chair transfer. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #69's Care Plan dated 03/26/2023 reflected he had a history of falls related to impaired mobility and self-transfers. Approach: call bell in reach, explain/encourage use and answer promptly. Observation and interview on 02/22/2024 at 8:35 AM Resident #69 was in his wheelchair and his call light was on the floor. His left leg was amputated at the hip. MA/CNA was present in the room and stated that having call lights on the floor could create fall risks if they try to get the call light off the floor and they do not have their needs met. In an interview on 02/22/2024 at 2:29 PM the ADON stated the problem with call lights out of reach or on the floor is that the resident cannot call for help. She stated her expectation was that the call lights should be clipped to the bed and If the call lights were not in reach, the potential danger was the resident might fall or get hurt. In an interview on 02/22/2024 at 2:53 PM the Nurse Consultant stated call lights should be within the residents reach and the potential risk to the resident was they might fall. She stated the nurse or CNAs were responsible for making sure the call lights were within reach and should be checking call lights every time they enter the rooms. In an interview on 02/22/2024 at 3:13 PM the Administrator stated she had been working at the facility one week. She stated her expectation was for call lights to be within reach of the resident as the resident might not be able to yell out or get help. She further stated every staff member who walks into the room should be responsible for making sure call lights are within reach. Record review of a facility policy and procedure titled Answering the Call Light dated 2001 and revised October 2010 reflected, Purpose: The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines: 5. When the resident is in bed or confined to a chair be sure the call light is in easy reach of the resident.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 40884 Based on interview and record review, the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life and failed to demonstrate their response and rationale for such response for one of one resident council meeting. There was no documentation of the facility's effort to resolve grievances collected at Resident Council meetings on 11/07/2023, 12/12/2023, and 01/09/2024. This failure placed residents at risk of indignity and diminished quality of life. Findings included: Review of Resident Council Minutes reflected the following with no resolutions or follow-up documented: -11/07/2023: Variety of Brief sizes, Nurses should help CNAs, missing clothing and clean under the beds. -12/12/2023: Call Lights not being answered, Not getting their briefs changed, Staff gossiping in front of residents, Medications are late, not getting showers, eggs and toast not good and second time they have complained about not cleaning under the beds -01/09/2024: CNAs does not return to residents' room after the resident's requests things or care, staff using ear buds and talking on the phone, call lights not being answered, Staff is gossiping in front of the residents. (Gossiping, Wearing ear buds, not answering call lights 2nd time to complain about these issues). During a confidential group interview on 02/21/2024 at 10:00 AM the group stated that they have been complaining about staff being on their phones when giving care and not talking to the residents. The call lights not being answered and having to wait approximately 45 minutes to an hour. The food was cold and needed a variety of food being served. The residents in the group agreed they have complained about not having enough linens especially wash cloths and towels to take a shower. The residents stated the Activity Director was present at all the meetings and documented the minutes. The residents stated the Activity Director would say she would take care of it and give it to the appropriate department head. The residents stated nothing ever happened and no one reported to the resident council group the results of the complaints or what the administration was doing to correct their concerns. The group stated the complaints voiced in Resident Council meetings in the past 3 or 4 months the group has not heard of any type of resolution or attempts to resolve any of the issues. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/22/2024 at 11:18 AM the Activity Director stated she did attend all Resident Council meetings with the approval of the residents. She stated the residents did voice grievances in Resident Council about the staff on their phones talking to family or friends and did not speak to the residents during care. She also stated the Resident Council group did voice concerns about call lights not being answered promptly and the food being cold. The Activity Director stated she did write grievances on the Resident Council concerns but did not follow-up with the grievances or report to the Resident Council about their grievances. She stated this was one of their resident rights to know updates on grievances they voiced during Resident Council. She stated she made a mistake when she did not report to Resident Council about grievances they voiced in prior meetings or follow-up on the grievances. In an interview on 02/22/2024 at 11:47 AM, the Administrator stated the Activity Director was expected to give grievances to the appropriate Department Head and discuss the grievances in the department head meetings. She stated the Activity Director was expected to report in the next Resident Council Meeting the results of the grievances or what the facility was doing to resolve the grievances. She stated this was the residents right to know the results of grievances. Review of the facility's Policy on Filing Grievances/ Complaints dated 01/2011, reflected our facility will help residents, their representatives (sponsors), other interested family members, or resident advocates file grievances or complaints when such requests are made. Record review of the facilities Resident Council Policy revised on 12/2006 reflected the facility supports residents' desires to be involved and have input in the operation of the facility through Resident Council. 1. The purpose of the Resident Council is to provide a forum for a. Residents to have input in the operation of the facility. b. Discussion of concerns. c. Consensus building and communication between residents and facility staff; and d. Staff to disseminate (spread) information and gather feedback from interested residents. 2. Minutes include names of the council members and any guests present; issues discussed; recommendations from the council to the Administrator; and follow-up on prior issues. Review of the facilities Policy on Resident Rights revised on 01/2011 reflected residents had a right to voice grievances and have the facility respond to those grievances.

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 40884 Based on observation, interviews, and record review the facility failed to place most recent survey readily accessible to residents in a place most frequented by residents for 9 of 9 residents reviewed for resident group meeting. The facility failed to have the survey manual readily accessible for the residents to view the surveys. This failure could place residents at risk of not being able to fully exercise their rights to be informed of the facility's survey citation history. Findings included: Observation on 02/20/2024 at 4:05 PM revealed the survey book was not located in the common areas of the facility. There was no sign revealing where the survey book was located. Observation on 02/21/2024 at 8:35 AM revealed the survey book was not located in the common areas of the facility. Observation on 02/21/2024 at 8:45 AM revealed a small sign after 15 minutes of attempting to locate a sign of survey book or the survey book. The sign was located on the corner of the tall receptionist desk was an 8x10 picture frame with sign stated survey results are available for review in the front waiting area in a white binder labeled KNR Survey Results. The print was small and was difficult to read it. The frame was too high for a resident in a wheelchair to be able to read the sign in the picture frame and it was to the corner of the desk and where the frame was located. Interview with the receptionist on 02/21/2024 at 8:50 AM she stated she did not know where the survey manual was located. She stated the sign was on her desk but she did not see it. She looked through several manuals and found the state survey manual with all the surveys in it behind the receptionist desk. The receptionist stated the state survey manual was sometimes on top of the receptionist desk. She stated the residents, visitors or family would not have access to the state survey manual behind the receptionist desk. (continued on next page)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	In a confidential group interview on 02/21/2024 from 10:00 AM to 10:35 AM, nine residents stated they did not know where or how to access the survey results in the facility. They did not understand or have the knowledge this manual existed in the facility. The residents in the group stated they would like to have access to this information, because the staff did not tell them anything about visits from the state. The residents in the group did not know the state sent a report to the facility of any type of visits. The residents in the group did not know where a sign was located informing the residents about the survey book. Five of the residents stated they sometimes went to the receptionist desk but never saw a sign. The five residents stated they only went to the lower part of the receptionist desk that faced the wall where the administrator office was located. The five residents stated they did not go around the receptionist desk where it was very high. They stated if the sign was on that section of the desk, they would not be able to see it or read it because the receptionist desk is high and they could not get their wheelchairs to that area. The nine residents in the group stated if they reviewed the reports in a manual, they would prefer to be able to reach it themselves and not have to ask for it. In an interview on 02/22/2024 at 11:18 AM the Activity Director stated the survey binder was not discussed in Resident Council of where it was located or the availability of the binder. She stated she did not know at this time where the survey binder was located. The Activity Director stated if the survey binder was behind the receptionist desk the residents, visitors or family would not have access to view the past surveys from state. She also stated the residents had a right to view the past surveys from the state. In an interview on 02/22/2024 at 11:47 AM the Administrator stated it was the residents' rights to have access to the past state surveys manual. She stated if the state survey manual was behind the receptionist desk the residents, visitors or families would not have access to the survey manual. The Administrator also stated where the sign was located on the receptionist desk would be difficult for residents to see or read the sign. She stated this resident right was expected to be reviewed in resident council. Record review of the Facility Policy on Resident Rights revised 01/2011 reflected resident had a right to examine survey results.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation, interview and record review the facility failed to maintain a clean, sanitary, comfortable, and homelike environment in 1 of 1 resident rooms (Resident #69) and 1 of 2 medication storage rooms (Pod 1 medication storage room) as evidenced by, 1) Resident #69 had feces on his commode, feces-soaked towels on his floor, and brown stains on his bedspread and wheelchair. 2) The Pod 1 medication storage room had loose trash, a box of ostomy bags, and debris and dirt on the floor. The interior of the specimen refrigerator had brown and yellow stains and chunks of brown debris. The freezer section had a large amount of unidentified brown debris. These failures could place all residents in the facility at risk for a diminished quality of life and a diminished clean, homelike environment. Findings included: 1. Record review of Resident #69's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Abscess of bursa (localized collection of pus in bursa, a small fluid filled sac located near joints that acts as a cushion between bones, tendons, and muscles) right hip, Muscle wasting and atrophy, unsteadiness on feet. Record review of Resident #69's Quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 11 indicating moderate cognitive impairment. Record review of Resident #69's Care Plan dated 03/26/2023 reflected a Problem start date of 08/21/2023. Resident has been observed urinating and having bowel movements in miscellaneous items such as cups and empty boxes. Long term goal: Resident will not have items with urine or BM stored in his room. Approach: Staff will monitor resident room every two hours. Observation on 02/20/2024 at 9:46 AM in Resident #69's room revealed the bedspread on his bed was dirty with brown stains, a towel on his wheelchair had brown residue, and the bathroom commode had brown stains on the seat and a piece of what appeared to be feces. There was a brown/yellow stain on the side of the commode. Observation on 02/20/2024 at 12:25 PM of Resident #69's bedspread revealed it still had the same brown stains on it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 02/22/2024 at 8:35 AM in Resident #69's room, MA/CNA stated there was an infection control issue due to all the feces around the room. She stated possible stool on sheets and in his wheelchair earlier in the week would be a concern about infection and dignity. She stated bedding should not be soiled. The bathroom and the floor in the room had soiled towels with brown residue that appeared to be feces. MA/CNA confirmed the towels smelled like feces and picked up both towels. She confirmed that was a sanitation issue. In an interview on 02/22/2024 at 9:03 AM LVN E stated the feces soiled towels in Resident #69's room were an infection control issue. 2. Observation on 02/21/2024 at 9:35 AM in the Pod 1 medication storage room revealed there was loose trash, a box of ostomy bags, and debris and dirt on the floor. The interior of the specimen refrigerator had brown and yellow stains and chunks of brown debris. The small freezer section had a large amount of unidentified brown debris. In an interview on 02/21/2024 at 9:41 AM LVN G stated she was an agency nurse (temporary nurse that works for a staffing agency), and the night nurses were supposed to keep the medication storage room clean. She stated in its current state it was dirty and unsanitary and she thought everything should be 6 inches off the floor. In an interview on 02/22/2024 at 9:07 AM LVN F stated she had worked at the facility for three years. She stated the medication room floor should not be dirty and it was. She stated the specimen refrigerator was dirty. She stated the dirty refrigerator and floor was an infection control issue and that housekeeping was responsible for cleaning, but housekeeping would have to get keys from a nurse to get into the room. She further stated it was the nurse's responsibility to clean the medication storage room (everything except for the floor). In an interview on 02/22/2024 at 9:16 AM the ADON and ADMIN agreed the specimen refrigerator and medication storage room floor were dirty and confirmed that it was an infection control issue. In an interview on 02/22/2024 at 2:53 PM the Nurse Consultant stated her expectation was that the medication storage room should be cleaned, but if housekeeping is cleaning in there a nurse must be present. She further stated cleaning the medication storage room is not on the housekeeping list and it was the nurse's responsibility to ask that it be cleaned if dirty. Record review of a facility Policy and Procedure titled Infection Prevention and Control Program dated 01/01/2024 reflected Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Standard Precautions: Environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department. 48314

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30633 Based on interviews and record review the facility failed to ensure residents had the right to be free from abuse and neglect for one resident (Resident #68) out of 18 reviewed for abuse. The facility to failed to ensure a social worker at the facility did not verbally abuse a resident when they yelled at Resident #68 and called him stupid; the incident was witnessed by the ADON, who reported it immediately. The failure could place residents at risk of physical or emotional distress, and injury. Findings include: Review of the Face sheet for Resident #68 reflected he was admitted on [DATE] with diagnosis of: Vascular Dementia, Anxiety, Acute Congestive heart Failure, Major Depressive disorder, Irritable Bowel syndrome, Acute Kidney Failure and Chronic Atrial fibrillation. Review of the annual MDS assessment for Resident #68 dated 10/29/23 reflected a BIMS score of 15 indicating normal cognitive abilities. His physical assessment reflected he was independent in performing all his ADLs. He was assessed as continent of bowel and bladder. Review of the Care Plan for Resident #68 reflected interventions were in place for: Behaviors (stating residents were having sex in the next room), convulsions related to seizure disorder, and Full Code status. Review of the Progress Notes for Resident #68 from 7/01/2 to 2/22/24 reflected He had been recommended for Psychiatric follow up and Psychotropic medication management on 2/05/24. Progress notes reflected incidents of verbal aggression towards staff, and redirection was not effective at times. Record review of the Incident Report for Intake #484813 reflected the ADON reported the incident on 2/16/24 at 8:55 am. She gave a statement at approximately 8:00 pm on 2/15/24 saying the Social worker told Resident #68 you are stupid. The Social worker appeared to be very agitated because she was called back to the facility by administration to do a medical records task. The resident was immediately assessed and reassured by staff members. The Administrator interviewed Resident #68 as soon as she became aware of the incident. The Social Worker was suspended during the investigation. The Resident stated he was not worried about the social worker and felt safe in the facility. The Resident's physician was notified about the incident. The Resident appeared calm when he retired to bed and no behaviors were noted by staff. A statement from the Social Worker dated 2/16/24 reflected she stated he had really got to her last night. She stated she overheard the Resident state she was not doing her job. She stated she called him stupid, he really got to her and she apologized. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff received inservice education on Abuse Neglect and Exploitation on 2/16/24. Review of the Policy for ANE dated December 2013 reflected Verbal Abuse is defined as any use of oral, written or gestures which are disparaging or derogatory to Residents. In an interview on 2/20/24 at 7:50 am Resident #68 stated he had no concerns about the incident with the social worker. He stated he was surprised when she got all up in his face and stated she did little to help him anyway. In an interview on 2/21/24 at 1:20 pm the Administrator stated the incident with Resident #68 and the Social Worker was not yet completed. She stated the Social Worker had been suspended during the investigation. She stated the Social worker was observed referring to Resident #68 as Stupid. She stated the incident occurred near the front entrance and was observed by Residents and staff. She stated Resident #68 and the ADON were walking towards the front. The Administrator stated Resident #68 was talking and the Social Worker came up to him and called him stupid. She stated the ADON reported the incident and the Social Worker was suspended. In an interview on 2/21/24 at 1:30 pm the ADON stated she was present when the Social Worker called Resident #68 stupid. She stated the Social Worker was called in to complete some essential paperwork for a resident discharge, and she was not happy about that. She stated Resident #68 was walking with her towards the front. She stated the Social Worker was sitting with some Residents in the Piano room. She stated the Social Worker heard something Resident #68 stated about reporting problems to the Social Worker. The ADON stated she would like to see the Social Worker removed from the facility for her behavior against Resident #68. She stated telling a Resident to shut up was not to be tolerated from anyone and was unprofessional. She stated all staff were aware residents can have behaviors but staff were not to react. Attempts to reach the social worker for interview on 2/20/24, 2/21/24 and 2/22/24 were unsuccessful at her supplied phone number.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on interview and record review, the facility failed to conduct an accurate comprehensive assessment of each resident's functional capacity for one (Resident #240) of eight residents reviewed for comprehensive assessments. The facility failed to ensure Resident #240's admission assessment was completed by the 14th day of admission. These failures placed residents at risk of not receiving the proper care required to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings included: Record review of Resident #240's Face Sheet, dated 02/22/2024, reflected a [AGE] year-old female admitted on [DATE] with diagnoses included muscle wasting and atrophy, not elsewhere classified, unspecified site (the decrease in size and wasting of muscle tissue), lack of coordination (muscle control problem that causes an inability to coordinate movement) difficulty in walking (inability to walk properly), chronic kidney disease (damage or loss of function in the kidneys), Pneumonia (an acute illness usually with cough as the main symptom), fluid overload (your body has too much water and the extra fluid can raise your blood pressure and force you heart to work harder), metabolic encephalopathy (problem in the brain- it is caused by a chemical imbalance in the blood), essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition). Record review of Resident #240's Admission MDS Assessment has not been completed. On 02/22/2024 the MDS was still in progress. Resident was admitted on [DATE]. In an interview on 02/22/2024 at 9:39 AM the Nurse Consultant stated Admission MDS Assessments was expected to be completed within 14 days of the admitted . She stated Resident #240's Admission MDS was in progress and had not been signed by a RN. She stated Resident #240 was admitted on [DATE] and the MDS was required to be completed and submitted by 02/14/2024. She stated someone from corporate office was completing Medicaid MDS Assessments. She did not know the person's name. In an interview on 02/22/2024 at 10:41 AM the MDS Coordinator/LVN stated she only completed Medicare MDS and was not familiar with the Medicaid MDS Assessments. She stated she could not respond to any questions about the Medicaid MDS. The MDS Coordinator/ LVN stated someone from corporate was completing the Medicaid MDS Assessments but she did not know the person's name. She stated it was someone different every week. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/22/2024 at 11:47 AM the Administrator stated the initial MDS Assessment was expected to be completed within 14 days of the admitted . She stated if Resident #240 was admitted on [DATE], her MDS was required to be completed on 02/14/2024. The Administrator stated if the electronic medical record shows it is in progress the MDS was not completed. She stated the Resident #240 may not receive the appropriate care she needs if there were no assessments from the interdisciplinary team. Review of the Facility's policy for Resident Assessment Instrument, dated 09/2001, reflected the assessment coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: 1. Within fourteen (14) days of the resident's admission to the facility. 2. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on interviews and record reviews, the facility failed to develop a comprehensive care plan within seven days after the comprehensive assessment was required to be completed for one (Resident # 240) of seven resident reviewed for comprehensive care plans. The facility failed to complete comprehensive person-centered care plan to address Resident #240's needs within seven days after the comprehensive MDS assessments was expected to be completed. This failure could place residents at risk of not having their individual care needs met in a timely manner or diminished quality of life. Findings included: Record review of Resident #240's Face Sheet, dated 02/22/2024, reflected a [AGE] year-old female admitted on [DATE] with diagnoses included muscle wasting and atrophy, not elsewhere classified, unspecified site (the decrease in size and wasting of muscle tissue), lack of coordination (muscle control problem that causes an inability to coordinate movement) difficulty in walking (inability to walk properly), chronic kidney disease (damage or loss of function in the kidneys), Pneumonia (an acute illness usually with cough as the main symptom), fluid overload (your body has too much water and the extra fluid can raise your blood pressure and force you heart to work harder), metabolic encephalopathy (problem in the brain- it is caused by a chemical imbalance in the blood), essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition). Record review of Resident #240's Admission MDS Assessment has not been completed. On 02/22/2024 the MDS was still in progress. Resident was admitted on [DATE]. Record review of Resident #240's Comprehensive Care Plan reflected the care plan was not completed when reviewed on 02/24/2024. Resident #240 had one problem on the comprehensive care plan dated 02/05/2024. Resident #240 prefers activities that identify with prior lifestyle. Goal: Resident #240 will express satisfaction with daily routine and leisure activities. Interventions: Allow Resident #240 to express feelings and desires. Arrange visits by volunteers. Inform Resident #240 of upcoming activities by providing an activity calendar, verbal reminders, encouragement and escorts. Involve Resident #240 with those who have shared interests. Praise involvement. In an interview on 02/22/2024 at 9:39 AM The Nurse Consultant stated the comprehensive care plan cannot be completed until the MDS Assessment has been completed. She stated there was a potential the nursing staff would not know what type of care Resident #240 would need if there was not a completed MDS or comprehensive care plan. She stated there was a possibility a staff was not aware of the appropriate method to use when transferring a resident. The Nurse Consultant also stated if the wrong method of transfer was used there was a possibility the resident may be injured during the transfer. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/22/2024 at 10:41 AM MDS Coordinator/ LVN stated the comprehensive care plan was expected to be completed 21 days after the admitted . She stated if Resident #240 was admitted on [DATE] her comprehensive care plan was expected to be completed on 02/21/2024. The MDS Coordinator/ LVN stated the care plan was a guide for the nursing staff and other staff to go by when giving care to the resident. In an interview on 02/22/2024 at 11:47 AM The Administrator stated if Resident #240 did not have a comprehensive care plan the nursing staff and other staff would not have the information, they needed to give care to Resident #240. She stated the staff has a guide on the electronic medical record that shows them what type of care each resident's needs. She also stated this information is derived from the comprehensive care plan. The Administrator stated on a new admit the comprehensive care plan was expected to be completed within 21 days of admission and baseline care plan was completed within 48 hours of admission. She also stated if the nursing staff did not know what type of ADL care Resident #240 required it was a possibility the nursing staff may give the wrong care such as: transfers, bathing, and other ADL care. The facility Policy on Care Plans, Comprehensive Person-Centered, revised on December 2016, reflected the comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment (MDS).

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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** 28689 40884 Based on observation, interview and record review, the facility the facility failed to provide the necessary services to maintain grooming and personal care for 6 of 10 residents (#4, #69, #81, #74, #12, and # 240) reviewed for ADL care. The facility failed to ensure Residents #4, #69, #81, #74, #12, and # 240 were provided assistance with personal hygiene. These failures could place residents at risk of skin breakdown, infection, and loss of self-esteem. Findings included: Record review of Resident #4's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease with acute exacerbation (group of disease that cause airflow blockage and breathing related problems), Cerebral Infarction (disrupted blood flow to the brain due to problems with blood vessels that supply and can cause death of brain cells), Dementia (a group of thinking and social functions that interferes with daily functioning), and difficulty in walking. Record review of Resident #4's quarterly MDS dated [DATE] reflected he required supervision or touching assistance for personal hygiene. Record review of Resident #4's Care Plan dated 01/23/20224 reflected he had a self-care deficit and required extensive assistance with ADLS. Long term goal: will be clean and free from odors with dignity. Nail care was not addressed. Observation and interview on 02/20/2024 at 8:41 AM of Resident #4's fingernails which were 1 long past his fingertips with brown debris underneath. His right great toenail was curled and 1.5 inches long past the tip of his toe. There was a foul odor noted when he removed his shoe. He had an unkempt beard and hair. He stated sometimes his toes hurt because his toenails were so long. Observation on 02/22/2024 at 8:23 AM revealed Resident #4 was in the television breakroom eating breakfast. His fingernails were still long with brown debris underneath, he had an unkempt beard and matted hair, He removed his right shoe revealing his 1.5-inch-long great toenail which was red. His foot emitted a strong, foul odor. Record review of Resident #69's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Abscess of bursa (localized collection of pus in bursa, a small fluid filled sac located near joints that acts as a cushion between bones, tendons, and muscles) right hip, Muscle wasting and atrophy, unsteadiness on feet, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #69's Quarterly MDS dated [DATE] reflected he required substantial/maximal assistance for personal hygiene. Record review of Resident #69's Care Plan dated 03/26/2023 reflected he had an amputation and will participate in self-care to his maximum potential. Approach: 08/22/2023 allow resident to complete as much of ADLS as able then staff to complete as needed. Observation on 02/20/2024 at 9:46 AM revealed Resident #69 had fingernails which were 1 long past his fingertips with brown/black debris underneath. His mustache was long and curling under into his mouth and he had a scruffy, unkempt beard and hair. His shirt had white food debris and brown stains on it. In an interview on 02/22/2024 at 08:26 AM the MA/CNA stated CNAs are the staff responsible for trimming nails unless the resident has diabetes, then the nurse would have to make arrangements for nail care. She stated the person/staff who showers a resident should be checking their nails and the problem with long nails is the resident could scratch themselves and cause an infection. She further stated It could be a dignity issue if the resident is used to being clean shaven and now is not being shaved because people would look at him differently. Observation and interview on 02/22/2024 at 8:35 AM Resident #69 was sitting in his wheelchair in his room and stated he was doing well. He stated he was unaware he had a problem with his nails but would be agreeable to having staff cut his nails. MA/CNA was present and confirmed Resident #69's clothes were dirty; his fingernails were long with brown/black debris underneath and his beard was long and had an unkempt appearance. She stated his long fingernails could be an infection issue due to all the feces around the room. In an interview on 02/22/2024 at 8:31 AM LVN E stated she had not had a chance to look at nails during her rounds today. She stated she normally looks at resident nails during her room rounds and she tells the CNA what residents showers are scheduled on the AM shift. Record review of Resident #81's undated Face Sheet reflected he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of pressure ulcer of sacral region (bedsore in area around the lower back and upper buttocks), and abnormalities of gait and mobility. Record review of Resident #81's Comprehensive MDS dated [DATE] reflected he required partial or moderate assistance for personal hygiene. Record review of Resident #81's Care Plan dated 11/12/2023 reflected it did not address ADL care. Observation and interview on 02/22/2024 at 8:44 AM Resident #81 was observed lying in bed. He had a scruffy beard, and long, dirty fingernails. MA/CNA was present and stated his unshaven beard and unkempt appearance was a dignity concern and his long, dirty fingernails were an infection control concern because he could scratch himself. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #74's undated Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Cerebral Infarction due to unspecified occlusion or stenosis of left vertebral artery (disrupted blood flow to the brain due to problems with blood vessels that supply and can cause death of brain cells), Pain in unspecified foot, and need for assistance with personal care. Record review of Resident #74's Quarterly MDS dated [DATE] reflected he required partial/moderate assistance with personal hygiene. Record review of Resident #74's Care Plan dated 03/27/2023 reflected he had a self-care deficit and required assistance. Long term goal target date: 05/05/2024. Will anticipate and meet needs while giving cues/directions to perform ADL at their ability. Approach: Provide/ assist with bath shower as per schedule or as needed. The Care Plan did not address nail care. Observation and interview on 02/22/2024 at 8:54 AM Resident #74 was observed in bed in a hospital gown. His skin was dry with large amounts of yellow/white flaky skin falling off onto his sheets. He complained of pain between his toes and under his foot. His feet were dirty, and his toenails were thick and long. MA/CNA was present and stated there was a dignity issue due to long toenails and an infection control issue with skin flaking onto the sheet. She further stated there appeared to be an infection on his toes/feet due to the crusty red appearance and she would notify the nurse due to the complaint of pain and appearance of his feet. When asked what training she had received regarding nail care she stated she recently had an infection control in-service training but had not received any training about what to do about long, dirty nails. Observation and interviews on 02/22/2024 at 9:03 AM Resident #74 stated his feet were hurting. LVN E observed his long toenails and fingernails and stated it was an infection control issue as he could scratch himself. She stated a podiatrist should come see him, but he had a habit of refusing services. She said she had an obligation to educate him about receiving services and stated she checked nails during her nursing rounds. Record review of Resident #12's undated Face Sheet reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included muscle wasting and atrophy, not elsewhere classified, unspecified site (thinning or loss of muscle tissue), age related cataract, left eye (cloudy areas formed on your eye's lens), type 2 diabetes mellitus with diabetic neuropathy, unspecified (uncontrolled blood sugar and neuropathy is pain and numbness in the legs, feet and hands), lack of coordination (clumsy movements and a wide range of conditions or circumstances, or it can happen as a stand-alone condition). Record review of Resident #12's Quarterly MDS Assessment, dated 12/18/2023, reflected Resident #12 had a BIMS score of 7 which indicated residents' cognition was severely impaired. Resident #12 did not reject care. Resident #12 did require assistance with ADLS including personal hygiene. Record review of Resident #12's Comprehensive Care Plan, dated 12/05/2023 reflected Resident #12 required assistance with ADLs. Observation on 02/20/2024 at 7:34 AM Resident #12 was lying in bed. Her nails on her right and left hand were long and jagged. Resident #12's nails was not smooth and was rough around the edges on all nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/20/2024 at 7:36 AM Resident #12 stated her nails were too long and she had scratched herself with the sharpest nail (middle fingernail on her right hand). She stated she had asked the staff to trim her nails over the past 2 weeks and no one would trim them for her. Resident #12 stated she did not recall the staff's names. Record review of Resident #240's undated Face Sheet reflected a [AGE] year-old female admitted on [DATE] with diagnoses included muscle wasting and atrophy, not elsewhere classified, unspecified site (the decrease in size and wasting of muscle tissue), lack of coordination (muscle control problem that causes an inability to coordinate movement) essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition). Record review of Resident #240's Admission MDS Assessment has not been completed. On 02/22/2024 the MDS was still in progress. Resident was admitted on [DATE]. Record review of Resident #240's Comprehensive Care Plan reflected the care plan was not completed when reviewed on 02/24/2024. There was only one problem on the care plan and that was the activity care plan. Observation on 02/20/2024 at 7:21 AM revealed Resident #240's nails had blackish substance underneath the middle, ring and fore fingernails on her right hand. She stated she asked someone last night to clean her nails and they did not return to my room to clean my nails. In an interview on 02/22/2024 at 8:32 AM, CNA A stated the nurses were responsible to trim and clean all resident's nails with a diagnosis of diabetes. She stated it was the CNA's responsibility to clean and trim all other residents' nails. CNA A stated the CNAs report to nurses of any diabetic resident's nails needed to be trimmed or cleaned. She stated the nurses makes rounds and check residents, with diabetes, nails. She also stated the CNAs usually did nail care when residents received a shower or as needed. CNA A stated if anyone observed a brownish and/or blackish substance underneath residents nails the nursing staff were expected to clean the resident's nails or ask the appropriate nurse to complete the nail care. She stated the blackish/ brownish substance possibility could be feces or any type of bacteria underneath the resident's nails. CNA A stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as diarrhea or vomiting. She also stated a resident may become dehydrated and may require to be transfer to hospital for further medical assessment. She also stated if resident had rough nails the resident may scratch themselves and possibly develop a skin tear or possibility may scratch someone else. She stated the nails was not expected to be sharp and uneven. In an interview on 02/22/2024 at 8:42 AM CNA C stated the CNAs were responsible for nail care unless a resident was a diabetic. She stated the CNAs usually trimmed and cleaned nails during showers. She stated the nails can be cleaned or trimmed by nurses or CNAs as needed. CNA C stated the nursing staff was expected to clean and trim residents' nails immediately if there was a blackish substance underneath the residents' nails and/ or if their nails needed to be trimmed. CNA C stated the blackish substance may be fecal matter underneath the residents' nails. She stated if a resident swallowed the blackish substance there was a possibility a resident may become ill with stomach issues or any type of intestinal issues. She stated a resident may need to be assessed at the emergency room if they became severely ill. CNA C stated if a resident had sharp nails, it could and the nails were rough around the edges the resident possibility may have skin infection from scratching themselves on their arms or legs. She stated she had been in-serviced on nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/22/2024 at 8:54 AM RN D stated it was the nurses and the CNAs responsibility to trim, cut, and clean residents' fingernails. She stated only the nurses can trim and clean residents with diagnosis of diabetes. RN D stated if there was a blackish substance underneath a resident's nails there was a possibility the substance was feces. She stated if a resident placed their finger in their mouth the feces could transfer from their fingers to their mouth. She also stated if the resident swallowed the feces or other bacteria a resident may develop a stomach infection such as E. Coli (a bacteria that is commonly found in the lower intestine and can cause serious food poisoning) and the resident may need to be treated at the emergency room . She stated the symptoms of a stomach infection may include the following: diarrhea, vomiting and/or loss of appetite. RN D also stated the CNAs completed nail care during showers and the CNAs would notify the nurses at that time if a resident with diagnosis of diabetes needed any nail care completed. She stated if a resident's nails were not trimmed properly and was rough at the tip of the nail, the resident had a potential of getting a skin tear from scratching themselves with sharp/uneven fingernails. In an interview on 02/22/2024 at 9:07 AM LVN F stated she had worked at the facility for 3 years. She stated it was everyone's responsibility to check residents (referring to soiled towels on floor, long toenails, long fingernails, giving resident's showers) and make sure the CNAs are doing their jobs. She stated it was usually the social worker's responsibility to put residents on podiatrist list but since they did not currently have a social worker she did not know who was currently responsible for that task. Observation and interview on 02/22/2024 at 9:20 AM the ADON and ADMIN observed Resident #4 in his room. The ADON stated his long fingernails and toenails were an infection control and dignity issue. Staff was observed cutting his fingernails. In an interview on 02/22/2024 at 9:25 AM the ADON and ADMIN stated it was an infection control and dignity issue (regarding Resident #69's long fingernails with brown/black debris underneath, his unkempt beard, and soiled clothes.) They both confirmed that would be an ADL concern. Staff was present in his room cutting his fingernails. In an interview on 02/22/2024 at 2:29 PM the ADON stated nurses oversee the monitoring of nail care, but CNAs should also be checking. She stated her expectation was that men and women need to be shaved for their dignity and their nails should be cut to an appropriate length so that the residents don't scratch themselves. She stated the social worker was in charge of putting residents on the list to see the podiatrist, however they did not currently have a social worker and there was not a backup plan in place. In an interview on 02/22/2024 at 2:53 PM the Nurse Consultant stated regarding ADL care (long fingernails, toenails, unshaven beard, dirty clothes) her expectation was residents should be offered to be shaved and/or have their nails trimmed during their showers. She stated the nurse and family should be notified if the resident is refusing and that the nurses should be looking at nails daily. She stated she was going to look in their care plan to see if they were orders for nails to be trimmed on Sundays and if not, she would put it in everyone's chart. She stated staff should be trimming nails on Sundays since residents do not have showers on that day. She further stated the risk to a resident of long fingernails and toenails is that they could have pain, could scratch themselves and get an infection. She also stated it could affect their dignity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/22/2024 at 3:13 PM the Administrator stated her expectation was that male and females should be kept clean shaven if they want and have their nails cut appropriately. She stated the risk of long nails could be infection control; they could get ulcers, and it was a dignity issue. She further stated nurses and CNAs should be performing nail care and a podiatrist should be used for trimming toenails if appropriate. She stated CNAs should clean nails and report concerns to nurses and nurses should be cutting the nails of diabetics to keep those residents safe. Record review of a facility policy and procedure titled Quality of Life - Accommodation of Needs dated 2001 and revised in August 2009 reflected Policy Statement. Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being.

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Killeen Nursing & Rehabilitation	5000 Thayer Dr Killeen, TX 76549

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview and record review the facility failed to provide, based on comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choices of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, encouraging interaction in the community for 3 of 6 residents (Resident #6, Resident #36 and Resident #37) reviewed for activities. The facility failed to ensure one-on- one activities for Residents #6, Resident #36 and Resident #37 was provided according to the one-one activity schedule. This failure could place residents at risk for a decline in social, mental, psychosocial well-being and a diminished quality of life. Findings included: 1. Record review of Resident #6's face sheet, dated 02/22/2024, revealed Resident #6 was an [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses legal blindness (you can see the first letter of the chart used by eye doctors to measure how clearly a person can see), unqualified vision loss (blindness or low vision in both eyes), age related physical debility (general weakness or feebleness that may be a result or an outcome of one or more medical conditions that produces symptoms such as pain, fatigue, physical disability, or deficits in attention, concentration, and memory), bilateral primary osteoarthritis of knee (occurs when the cartilage (connective tissue) in both knees wears away, causing a person's bones to rub together), reduced mobility (any person whose mobility to use transport is reduced due to physical disability), depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities). Record review of Resident #6's Annual MDS assessment dated [DATE], reflected Resident #6 had a BIMS score of three, which indicated the residents' cognition was severely impaired. According to section F it was very important for resident to go outside to get fresh air when the weather was good. It was somewhat important for her to listen to music she likes. Resident #6 was assessed to have severely impaired vision (no vision or sees only light, colors or shapes; eyes do not appear to follow objects). Record review of Resident #6's Quarterly MDS assessment dated [DATE], reflected Resident #6 had a BIMS score of three, indicated the resident's cognition was severely impaired. Resident #6 was assessed to have severely impaired vision (no vision or sees only light, colors or shapes; eyes do not appear to follow objects). Record review of Resident #6's Comprehensive Care Plan dated 11/30/2023 reflected the following *Resident #6 did not prefer to attend activities with other residents. Resident #6 will be offered in room activities to prevent boredom and social isolation. Resident #6 was at risk for mood instability related to diagnosis of depression. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Resident #6 prefers activities that identify with prior lifestyle. Interventions: provide books, magazines, and radio. *Resident #6 prefer setting for activities was her room. Resident #6 has impaired vision related to diagnosis of being legally blind. She also was assessed to have cognitive loss or alteration in thought processes related to impaired decision-making ability, short and/or long-term memory loss. Intervention: Provide a program of activities that accommodates resident's problem. Engage in structured activities, and sensory stimulation activities. Record review of Activity One-to-One (in room activities) Manual reflected Resident #6 was listed in the manual. Record review of Resident # 6's record of One-to-One (in room activities) record reflected Resident #6 did not receive one-to-one activities (in room activities) during the month of January 2024 and February 2024. The form for Resident #6 reflected room visits 2 times per week. Encourage Resident #6 to attend music and church activities. Record review of Activity Group Participation records reflected Resident #6 did not attend group activities for the months of January 2024 and February 2024. Interview on 02/22/2024 at 11:18 AM the Activity Director stated one-to-one activities was the same as in room activities. She stated everyone received in room activities was in the one-to-one manual. She stated Resident #6 did not receive any in room activities for the months of January and February 2024. She stated she did not have an answer of why Resident #6 did not receive these visits. The Activity Director also stated if Resident #6 attended any group activities it would be documented on her group participation record. She stated this record was named individual activity program participation record. She stated if Resident #6 did not have any documentation on her participation record this indicated Resident #6 did not attend any group activities during the months of January and February 2024. She stated Resident #6 had potential of becoming more depressed and possibly have social isolation without any type of stimulation. The Activity Director stated it was her responsibility to ensure all residents received activities according to their past and/or current interest. She stated it was also important to consider each residents physical/mental abilities. The Activity Director stated she realized how important in room activities were to the residents and their quality of life. Observation on 02/22/2024 at 1:30 PM Resident #6 was in her room without any stimulation. Resident #6 eyes were opened and she was staring toward the wall in front of her. Interview on 02/22/2024 at 1:33 PM Resident #6 did not respond to questions related to her activity preferences or in room activity visits. Resident #6 was not interviewable. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #'s 36 face sheet, dated 02/22/2024, revealed Resident #36 was an [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses traumatic hemorrhage of right cerebrum without loss of consciousness, subsequent encounter (caused by a blow or other traumatic injury to the head), unspecified dementia, mild, with anxiety (multiple types of mental and physical conditions are present at once), anxiety disorder (cause constant fear and worry), contractures of the following: right lower leg, right wrist, right hand, and right knee (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity, and rigidity of joints) -deformity (a part of someone's body which is not the normal shape because of injury or illness, or because they were born this way), and seizures (causes temporary abnormalities in muscle tone or movements, behaviors, sensations of states of awareness). Record review of Resident #36's Annual MDS assessment dated , 09/22/2023, reflected Resident #36 had a BIMS score of 3 indicated her cognitive status was severely impaired. According to section F she was assessed listening to music was somewhat important to her. Resident #36 was also assessed going outside to get fresh air when the weather permits was very important to her Record review of Resident #36's Significant Change MDS assessment, dated 12/18/2023, reflected Resident #36 was rarely/never understood. The staff assessed her cognition. Resident #36 was assessed with short- and long-term memory problems and Resident #36's decision making ability was severely impaired. According to section F it was very important for resident to go outside to get fresh air when the weather permitted. Record review of Resident #36's Comprehensive Care Plan assessment dated [DATE] reflected Resident #36 preferred activities were related to Resident #36's prior lifestyle. She will allow in room visits. Interventions: Provide one-to-one activities with resident two times per week. Resident #36's preferred setting for activities is her room. Resident #36 was also assessed to be at risk for social isolation. Intervention: offer in room activities. Resident #36 had cognitive loss and alteration in thought processes, impaired decision-making ability and short-long-term memory loss. Intervention: Provide a program of activities that accommodates resident's problem. Engage in structure activities, and sensory stimulation activities. Record review of Resident # 36's record of One-to-One (in room activities) record reflected Resident #36 did not receive one-to-one activities (in room activities) during the month of January 2024 and February 2024. The form for Resident #36 reflected provide room visits two-three times per week. Record review of Activity Group Participation records reflected Resident #36 did not attend group activities for the months of January 2024 and February 2024. Interview on 02/22/2024 at 11:18 AM the Activity Director stated Resident #36 remained in bed majority of the time due to decline in health. She stated Resident #36 was on the list to receive one-to-one activities (in room visits). The Activity Director stated Resident #36 did not receive one-to-one (in room activities) or attend group activities during the months of January 2024 and February 2024. She stated she did not know why Resident #36 did not receive in room activities and she was not physically able to attend group activities. Activity Director stated when residents do not receive any type of activities there was a potential the resident may become depressed, increase anxiety, the resident may become bored and have a decline in their cognition. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation/Interview on 02/22/2024 at 1:50 PM Resident #36 was in her room lying on her bed. Resident #36 opened her eyes and moved and stared toward the ceiling. She was not interviewable. There was not any stimulation in Resident #36's room. 3. Record review of Resident #'s 37's face sheet, dated 02/22/2024, revealed Resident #37 was a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses cognitive communication deficit (difficulty with thinking and how someone uses language), Unspecified fracture of the upper end of right humerus with routine healing (usually caused by falls), contracture of muscle, right lower leg (makes movement difficulty), Chronic obstructive pulmonary disease (makes breathing difficult), and hemiplegia and hemiparesis following encephalopathy (a mild or partial weakness or loss of strength on one side of the body). Record review of Resident #37's Annual MDS assessment dated [DATE], reflected Resident #37 had a BIMS score of two indicated Resident #37's cognition was severely impaired. Resident was assessed with some interest with listening to music and going outside to get fresh air when the weather permitted. Record review of Resident 37's Quarterly MDS assessment dated [DATE] (activities does not document on quarterly assessments), reflected Resident #37 had a BIMS score of one indicated Resident #37's cognition was severely impaired. Record review of Resident #37's Comprehensive Care Plan dated 01/27/2024 reflected Resident #37 was at risk for social isolation. She did not always prefer to leave her room. Resident #37 had cognitive loss and alteration in thought process related to impaired decision-making ability, short- and long-term memory loss. Resident #37 had a BIMS score of two. Interventions: provide a programs of activities that accommodates resident's cognitive status. Engage Resident #37 in structured activities and sensory stimulation. Resident #37 preferred activities that identify with prior lifestyle. Intervention: Encourage Resident #37 to become involved with activities. Record review of Resident # 37's record of One-to-One (in room activities) record reflected Resident #37 did not receive one-to-one activities (in room activities) during the month of January 2024 and February 2024. The form for Resident #37 reflected provide room visits two times per week and Resident #37 will attend one activity per week. Record review of Activity Group Participation records reflected Resident #37 did not attend group activities for the months of January 2024 and February 2024. Observation/Interview on 02/22/2024 at 2:10 PM Resident #36 was in her room lying in bed. She was not interviewable. Resident #37 would make eye contact less than 3 minutes and began to stare at the wall in front of her. A television was on in Resident #37's room, however, she was not watching the television during visit. Resident mostly stared at the wall in front of her. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/22/2024 at 11:18 AM the Activity Director stated Resident #37 did not prefer to be out of room very often. She stated Resident #37 enjoyed music and there was not a radio or any type of music in her room except what was on the television. The Activity Director stated Resident #37 would benefit receiving in room activities and discuss music with her or play music during the visit. She stated she would benefit from having her favorite music playing in her room. She also stated Resident #37 had a potential of becoming socially isolated due to not receiving visits from the activity staff or from volunteers. The Activity Director stated with Resident #37 not receiving in room activities during the months of January and February of 2024, Resident #37 had a potential of becoming bored and may a possibility of a decline in cognition and increase being depressed. She stated one-on-one activities was the same as in room activities. The activity director stated she did not have any group participation records or any one-on-one activity participation records for Resident # 6, Resident #36, or Resident #37. She stated these three residents did not receive one-on-one visits or attend any group activities for the months of January or February 2024. Interview on 02/22/2024 at 11:47 AM The Administrator stated she expected the residents on the in-room program to be visited 2-3 times per week. She stated if the activity staff were required to document all activities on the facilities forms. She stated if the activity staff did not document on the required activity forms the activity did not occur with the residents. She sated the residents on the in-room activity program had a potential of a decline with emotional, mental and/or physical decline by not having stimulation from activity programming. She stated activity programs enhances the resident's quality of life. The Administrator stated she was responsible for monitoring the Activity Department. She also stated she had only been in the facility less than a week and she did not know the former Administrators process of monitoring the Activity Department. After reviewing Resident #6, Resident #36, and Resident #37's in room and group activity participation record, she stated these residents did not receive activities for the months of January and February 2024. Record review of Facility's Activity Program Policy, dated 01/2011, reflected our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Activities are scheduled seven days a week. Our activity programs consist of individual and small and large group activities that are designed to meet the needs and interests of each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care accordance with professional standards of practice for one (Resident #29) of four residents reviewed for quality of care. The facility failed to assess Resident #29 prior to moving resident after a fall from her bed to the floor. This failure placed residents at risk for potential delay in medical intervention, decline in health and a decreased quality of life. Finding included: Record review of Resident #29's face sheet, dated 02/22/2024, revealed Resident #29 was an [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses which included repeated falls (older adults which falls more than once a year), dizziness and giddiness (dizziness- a general feeling of being off-balance. Giddiness- feeling that you are your surroundings are moving or spinning), muscle weakness (when full effort does not produce a normal muscle contraction or movement), wedge compression fracture of fourth lumbar vertebra, initial encounter for closed fracture (the bone actually collapses and forms a wedge shape- may stretch the spinal cord and create injury), other sequelae of cerebral infarction (develop a variety of medical, and psychosocial (pertaining to the influence of social factors on an individual's mind or behavior) complications, years after stroke), and Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by nerves). Record review of Resident #29's Quarterly MDS assessment, dated 11/16/2023, reflected Resident #29 had a BIMS score of seven, which indicated the residents' cognition was severely impaired. Resident #29 required assistance with ADLs. She required supervision with transfers. Resident #29 did not have any falls prior to this assessment. Record review of Resident #29's Comprehensive Care Plan completed on 01/28/2024 reflected Resident #29 had a history of falling related to ambulating without assistance and impaired bed mobility. Intervention: Make sure resident bed is in lowest position. Occupational Therapy will place [NAME] in room to remind resident not to ambulate without assistance. Resident #29 was at risk for falling related to impaired cognition and impulsiveness. Interventions: give resident verbal reminders not to ambulate/ transfer without assistance. Encourage Resident to assume a standing position slowly. Physical Therapy and Occupational Therapy to evaluate and treat. Assure the floor is free of glare, liquids, foreign objects. Keep personal items and frequently used within reach. Nonskid socks on at all times, resident does not like to wear shoes. Remind Resident #29 not to ambulate without assistance. Record review of Resident #24's pain assessment dated [DATE] reflected Resident #24 did not have any pain. Record review of Resident #24's head to toe assessment reflected Resident #24 did not sustain any injury. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/20/2024 at 9:39 AM heard a resident yelling for help and entered Resident #29's room and observed her sitting by her bed on the floor facing the head of the bed. Asked for assistance and within 2 minutes the Director of Therapy entered the room and less than a minute later LVN B entered Resident #24's room and immediately stated to the Director of Therapy do not move Resident #24 or do anything to Resident #24 until a pain assessment, vital signs and other assessments are completed. LVN B stated we cannot move a resident when they fall until all assessments are completed. The Director of Therapy stated to LVN B I know what I am doing I am a therapist and she is in an awkward position and I will move her. The Director of Therapy ignored LVN B's instructions of not moving Resident #24 and LVN B was unable to get to Resident #24 in time before the Director of Therapy picked Resident #24 off the floor and placed her on bed. LVN B continued to ask Director of Therapy not to touch Resident #24 until assessments was completed by nursing and needed to get Resident #24's vital signs. The Director of Therapy continued to ignore LVN B and began range of motion on Resident #24's extremities before any assessments or vital signs were completed by the nursing staff. In an interview on 02/20/2024 at 9:50 AM, LVN B stated no one was to move Resident #24 when she was sitting on the floor until pain assessments, neuro checks, head to toe assessments, and vital signs were completed. She stated the Director of Therapy did everything wrong when someone finds a resident on the floor. LVN B stated it was the facilities protocol not to move a resident until all these assessments and vital signs are completed. She stated at that time was when a nurse determined whether the resident needs an x-ray at the facility or transferred to emergency room . LVN B stated she did not know why the Director of Therapy ignored her instructions of the protocol of the facility. She stated there was a possibility if Resident #24 had an injury, the injury had a potential of becoming worse when the Director of Therapy moved Resident #24 immediately from the floor to the bed without completion of pain or skin assessments and monitoring vital signs. LVN B stated she could not speculate of what type of injuries Resident #24 may have received with the Director of Therapy not following proper facility protocol. In an interview on 02/20/2024 at 10:00 AM, the Director of Therapy stated if a resident was in an awkward position after a fall it was required for the staff to move the resident from the floor to the bed. She did not state when she learned this information. She stated completing range of motion on a resident was a requirement before any type of assessments were completed by staff. The Director of Therapy also stated if she was not in the facility the CNA was allowed to do assessments on the residents after a fall if the nurse or therapy was not available. The Director of Therapy stated, everything I just said I realize was wrong. She stated she was so accustomed to assisting residents she forgot anytime a resident fell the nurse was required to do head to toe assessment on resident and pain assessment on resident before Resident #24 was moved from the floor. The Director of Therapy stated everything she did for Resident #24 was completely wrong and she just realized she made all types of errors in the situation of Resident #24's fall. She stated she was expected to move away from Resident #24 as soon as LVN B entered the room. She stated she did not listen to LVN B directions and she did hear LVN B inform her not to touch or move Resident #24 until LVN B completed pain assessments, head to toe assessment and completed vital signs. She stated she ignored LVN B's directions. She stated she made a huge mistake and what she did with Resident #24 by moving her from floor to bed and doing range of motions immediately had a potential of hurting Resident #24 physically. She stated she accepted full responsibility of not following the facility protocol when finding a resident on the floor. The Director of Therapy also stated she had been in serviced on falls and in the in-services, it did state not to move a resident until the nurse completes assessments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/21/2024 at 7:00 AM the Nurse Consultant stated the Director of Therapy was not to move Resident #24 from the floor after Resident #24 fell . She stated as soon as LVN B entered the room and requested the Director of Therapy to not move her until after she assessed resident, the Director of Therapy was expected to stop immediately and follow the nurse's directions. She stated the resident was expected to receive a pain assessment, head to toe assessment, and neuro checks prior to moving Resident #24. The Nurse Consultant also stated this was not the facilities protocol and the Director of Therapy did everything wrong when finding a resident on the floor after a fall. She stated she could not answer if Resident #24 had an injury if the range of motion from the Director of Therapy would made the injury worse than what it was prior to the range of motion. She stated it was nursing protocol to assess residents prior to moving the resident from the floor or any surface after a fall. In an interview on 02/22/2024 at 11:47 AM, the Administrator stated it was the facilities protocol if a resident was found on the floor after a fall, the resident was not to be moved until the nurse completed pain assessment, neuro checks, and completed a head-to-toe assessment. She stated if the nurse was in the room and the Director of Therapy was expected to follow the nurses' instructions. The Administrator also stated the Director of Therapy did not follow facility protocol. She stated the Director of Therapy was not to move Resident #24 until the nurse completed her assessments. The Administrator stated not completing assessments after a resident fell and moved a resident from floor to bed had a potential to injure the resident or if a resident had an injury from the fall the injury could be a lot worse by not following the proper protocol. She stated the nurses was expected to oversee what all staff were to do when a resident fell and not the Director of Therapy. In an interview on 02/20/2024 at 5:37 PM requested from the Administrator in-services on fall protocol prior to 02/20/2024. Did not receive prior to exit. In an interview on 02/20/2024 at 12:55 PM requested from the Administrator in-services on fall protocol prior to 02/20/2024 and requested Quality of Care Policy. Did not receive prior to exit. Review of the facility Policy on Falls- Clinical Protocol Assessment and Recognition revised in 2012, reflected the nurse shall assess and document the following: vital signs, neurological status, and pain.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 30633 Based on observation, interview, and record review the facility failed to ensure that the residents' environment remained as free of accident hazards as was possible in 6 (room [ROOM NUMBER], 504, 506, 701, 707, and 801) of 38 resident room sinks and 1 (600 Hall Shower) of 2 resident shower rooms reviewed for hot water in the facility's 500 - 800 hallways. The facility failed to maintain resident use hot water at safe and comfortable temperatures (between 100-110). Resident use hot water was not reliably controlled and ranged from between 117.1 F and 145.0 F in reviewed locations. These failures resulted in an Immediate Jeopardy (IJ) situation on 03/12/2024. While the IJ was removed on 03/13/2024 the facility remained out of compliance at a severity level of no actual harm at a scope of pattern due to staff needing more time to monitor the plan of removal for effectiveness. This failure could place residents at risk for sustaining scalding injuries when using resident-use / resident accessible hot water. Findings included: Review of Resident #73's Face Sheet dated 02/21/2024 reflected that she was admitted to the facility on [DATE] with the following diagnosis: NSTEMI (less severe form of a heart attack because it inflicts less damage to the heart) and Dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday activities). Review of Quarterly MDS Assessment for Resident #73 dated 11/18/2023 reflected a BIMS score of 9 indicating moderate cognitive impairment. Review of Resident #68's Face sheet dated 02/22/2024 reflected that he was admitted to the facility on [DATE] with the following diagnosis: Vascular Dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), Acute Congestive Heart Failure (the heart is beating but cannot deliver enough oxygen to meet the body's needs). Review of the Annual MDS Assessment for Resident #68 dated 10/29/23 reflected a BIMS score of 15 indicating normal cognitive abilities. His physical assessment reflected he was independent in performing all his ADLs. Observation on 02/21/2024 at 7:38 AM, the hot water from the sink in room [ROOM NUMBER], which was occupied by Resident #73 was checked with a digital thermometer and found to be 130.5 F. Observation on 02/21/2024 at 8:43 AM, the hot water from the sink in room [ROOM NUMBER], which was occupied by Resident #68 was checked with a digital thermometer and found to be 145.0 F. (continued on next page)

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	676438	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Killeen Nursing & Rehabilitation	5000 Thayer Dr Killeen, TX 76549

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 02/21/2024 at 9:50 AM, the hot water from the sink in room [ROOM NUMBER] was checked with a digital thermometer and found to be 137.3 F. Observation on 02/21/2024 at 9:53 AM, the hot water from the sink in room [ROOM NUMBER] was checked with a digital thermometer and found to be 117.1 F. The shower head in the room was also checked and found to be 133.5 F. Observation on 02/21/2024 at 9:55 AM, the hot water was checked in the 600-hallway shower room at the shower head with a digital thermometer and found to be 133.5 F. Interview and observation on 02/21/2024 from 10:10 AM until 10:43 AM with the facility's Maintenance Director. The Maintenance Director stated that they want to maintain a safe water temperature in the facility of between 107 F and 110 F. The Maintenance Director stated that they perform water temperature tests of three to four random rooms and try to do so daily or at least every other day. The Maintenance Director stated that if the reading does show high they do not adjust the boiler immediately because the temperatures can fluctuate but will make adjustments if it becomes a pattern and at temperatures of 115 F and above. The Maintenance Director stated that elevated water temperatures could result in skin burns to residents but was not able to state to what degree and exposure time required. The Maintenance Director stated that the facility has two boilers for resident rooms in the 500 - 800 hallways. The Maintenance Director showed Surveyor the mechanical room with the two boilers for the 500 - 800 hallways. Boiler 1 displayed a digital tank temperature of 136 F and a set point (The temperature of the thermostat in order to maintain the desired temperature) of 149 F. Boiler 2 displayed a digital tank temperature of 135 F and a set point of 150 F. The thermometer past the hot water regulator for resident rooms displayed 136 F. The Maintenance Director stated that they have had some issues with the 500 - 800 boilers, which is why their set points are high. The Maintenance Director stated that the amount of hot water that is pushed into the system is controlled by an adjustable regulator past the boilers. The Maintenance Director stated that when they do their water temperature test in the rooms they do so with a digital thermometer and leave it under the water until the temperatures stops increasing. room [ROOM NUMBER] sink hot water was tested and displayed 137.0 F, which was verified with Surveyor's thermometer that displayed 137.4. room [ROOM NUMBER] sink hot water was tested and displayed 136.0 F. room [ROOM NUMBER] sink hot water was tested and displayed 137.8 F. room [ROOM NUMBER] sink hot water was tested and displayed 130.8 F. The Maintenance Director stated that he was going immediately to adjust the regulator for the 500 - 800 hallways to lower the temperatures and would continue to monitor. In an interview on 02/21/2024 at 11:37 AM, the Administrator stated that they wanted water temperatures to be between 106 F and 109 F. The Administrator stated that elevated water temperatures could result in a resident's skin being burned. At 12:00 PM, the ADMINISTRATOR stated that to her knowledge no resident had been burned by hot water during her time in the facility but told Surveyor to speak with the ADON who has worked in the facility longer. In an interview on 02/21/2024 at 12:04 PM, the ADON stated that elevated water temperatures in resident rooms could result in skin burns. The ADON stated that she had been with the facility for over three years and that no resident during that time had sustained a skin burn due to hot water. Observation on 02/21/2024 at 4:49 PM, the hot water from the sink in room [ROOM NUMBER] was checked with a digital thermometer and found to be 123.1 F down from 137.3 at 9:50 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 02/21/2024 at 4:55 PM, the hot water from the sink in room [ROOM NUMBER] was checked with a digital thermometer and found to be 124.7 F down from 137.0 F at 10:32 AM. Observation on 02/22/2024 at 9:37 AM, the hot water from the sink in room [ROOM NUMBER] was checked with a digital thermometer and found to be at 108.3 F and the shower head at 107.2 F. Interview and Observation on 02/22/2024 at 9:55 AM, the Maintenance Director stated that the facility boilers were now being adjusted via the tank settings and not by way of the regulator. Hallway 500 - 800 tank 1 now displayed a temperature of 115 F and a set point of 123 F. Hallway 500 - 800 tank 2 now displayed a temperature of 119 F and a set point of 125 F. The temperature after the regulator now displayed 110 F. Observation on 02/22/2024 at 5:42 PM, the hot water was checked in the 600-hallway shower room at the shower head and displayed a temperature of 100.6 F. Observation on 02/22/2024 at 5:49 PM, the hot water from the sink in room [ROOM NUMBER] was checked with a digital thermometer and found to now be at 116.6 down from 145.0 F on 02/21/2024 at 8:43 AM. Observation on 02/22/2024 at 7:01 PM, the hot water from the sink in room [ROOM NUMBER] was checked with a digital thermometer and found to now be at 110.5 F and 94.6 F at the shower head. Review of facility water temperature log indicated the following recorded dates and room hot water temperatures in Fahrenheit. February 13, 2024, Rooms 712 at 110, 710 at 112, 708 at 113, and 604 at 112. February 16, 2024, Rooms 604 at 109, 602 at 104, and 712 -at 110, February 16, 2024, Rooms 713 at 110 Review of facility's Maintenance Manual for 2024, dated November 2023 revealed, Maintenance Checklist, Daily Tasks 4. Test water temperatures on a different resident room each day and update log. TEST WATER TEMPERATURE: Test (4) different rooms each day, Ensure patient room water temperatures are between 100 to 110 degrees Fahrenheit, Check resident rooms at the end of each wing on a rotating basis, Let the water run for a least three minutes before taking your reading. Record Results in the Water Temperature Log: Note any discrepancies, Adjust water heater settings as required, Retest as necessary. Review of the facility's Grievance log did not reveal any complaints of water temperature being too hot. Review of facility's incident and accidents did not reveal any injuries to residents due to hot water. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the current undated American Burn Association Scald Injury Prevention Educator's Guide provided the following information: .although scald burns can happen to anyone, .older adults and people with disabilities are the most likely to incur such injuries .High Risk groups .Older Adults .Older adults, .have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred. Because they have poor microcirculation, heat is removed from burned tissue rather slowly compared to younger adults . People With Disabilities or Special Needs .Individuals who may have physical, mental or emotional challenges or require some type of assistance from caregivers are at high risk for all types of burn injuries including scalds sensory impairments can result in decreased sensation especially to the hands .so the person may not realize if something is too hot. Changes in a person ' s perception, memory, judgment or awareness may hinder the person ' s ability to recognize a dangerous situation .or respond appropriately to remove themselves from danger . Further review of the Guide revealed that 100-degree F water was a safe temperature for bathing. Water at 120 degrees F would cause a third-degree burn (full thickness burn) in 5 minutes and 124 degrees F water would cause a third-degree burn in 3 minutes. The Guide further documented that water at 127 degrees F caused third degree burns in 1 minute, 133 degrees F in 15 seconds, and 140 degrees F in 5 seconds. The Administrator was notified of the Immediate Jeopardy on 03/12/2024 at 11:51 AM and the IJ template was provided. The Administrator expressed understanding of the Immediate Jeopardy and a Plan of Removal was requested. The Plan of Removal was approved as follows: SURVEY TYPE: Annual Survey SURVEY DATE: 3/12/2024. Plan for REMOVAL Plan to remove immediate jeopardy. The facility failed to ensure residents had safe water temperatures in their bathroom sinks and shower rooms. F689 On 3/12/2024 the Administrator and Assistant Director of Nursing notified the Medical Director of immediate jeopardy. On 3/12/2024 Maintenance Director/Designee checked all residents' bathroom sinks, shower rooms, and all resident accessible water sources in the facility to make sure water temperatures were below 110.1F. On 3/12/2024 Regional Nurse Consultant/Designee checked all residents for any skin burns and document in EHR under progress notes for each resident. No residents were identified who had any skin burns. The Medical Director was updated on the assessments. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	COO (Chief Operating Officer) completed 1:1 in-service with Administrator on Water Temperature policy and Regional Nurse consultant completed 1:1 in-service with Assistants Director of Nursing on Water temperature policy, reporting any concerns or complaints, including water temperatures to Administrator upon discovery, and on risk factors for scalding/burns in the elderly, signs and symptoms of burns, and changes in condition on 3/12/2024. On 3/12/2024 Administrator completed in-services with Maintenance Director and IDT (Interdisciplinary team) water temperatures in residents' rooms, showers, and all resident accessible water sources to be below 110.1 and checking water temperatures daily. On 3/12/2024 Assistant Director of Nursing/Designee in-service staff on reporting any concerns or complaints regarding water temperatures to Maintenance Director or Administrator upon discovery. Direct Care staff will be in-serviced by ADON/Designee on risk factors for scalding/burns in the elderly, signs and symptoms of burns, and changes in condition. All staff, including the Agency, newly hired staff, and PRN will receive in-service and will not be allowed to start work until completed regarding reporting complaints and concerns from residents . The administrator will ensure all staff have completed in-services and training prior to starting work. The training will be completed by 3/12/2024. Ad-Hoc QAPI meeting was held on 3/12/2024, with the Medical Director, NHA (Nursing Home Administrator), Regional Nurse Consultant, Assistant Director of Nursing, and MDS Coordinator to review the deficiency and the plan for removal of immediacy. Starting on 3/12/2024, Maintenance Director/Designee will check all residents' rooms and shower rooms in the facility water temperatures daily Monday to Friday, and Manager on Duty Saturday and Sunday x 1 month. The findings will be immediately brought up to the Administrator for further action, if necessary, as an on-going process. The Administrator/designee will monitor compliance by completing an audit of five (5) residents' rooms/shower rooms per week for four (4) weeks to make sure water temperatures stay below 110.1F. This will be initiated on 3/12/2024. Any identified concerns will be addressed immediately and if trends and patterns are identified, the facility will conduct an Ad-Hoc QAPI meeting to discuss if additional interventions are needed to ensure compliance for the next 2 months. The Administrator will be responsible for ensuring this plan is completed on 3/12/2024. The RDO will provide oversight of Administrator to ensure that the items on the plan of removal are reviewed and completed. The Plan of Removal was monitored from 03/12/2024-03/13/2024 and is as follows: In observations on 03/13/2024 Water Temperatures in Resident Rooms were as follows: 1:57 pm room [ROOM NUMBER] - 85 degrees 2:00 pm room [ROOM NUMBER] - 92 degrees 2:04 pm room [ROOM NUMBER] - 100 degrees 2:10 pm room [ROOM NUMBER] - 92 degrees (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2:13 pm room [ROOM NUMBER] - 100 degrees 2:16 pm room - 601 - 102 degrees 2:20 pm room [ROOM NUMBER] - 103 degrees 2:24 pm room [ROOM NUMBER] - 102 degrees 2:28 pm The boiler temperatures for hallways 5 - 8 was 104 degrees. 2:32 pm The boiler temperatures for hallways 1 - 4 was 109 degrees. In an interview on 3-13-24 at 3:01 PM the ADM stated she was in-serviced by the COO about water temperatures. The temperature should not exceed 110.1 degrees. The risk factor if it does exceed this temperature is potential burns. This population is more at risk because elderly have thinner skin. Residents might not understand how to adjust the temperature settings, they might have a diagnosis that makes them more susceptible to getting burned. Residents might have nerve issues and they might not feel the burn and residents are slower in movement. They reviewed protocols that staff need to notify maintenance if residents have complaints that water is too hot or staff feel water is too hot. On 3-13-24 at 3:12 pm the Regional Nurse Consultant was in-serviced by COO. They reviewed the policy about the water temperatures. The water temperatures should be below 110. If staff feels temperatures were too high the resident should be assessed by a nurse and the nurse would tell the ADM and maintenance. CNAs can also tell ADM and maintenance but if CNAs are concerned about skin damage, they need to inform a nurse. She in-serviced the ADONs about water temperatures, burns and change in condition. In an interview on 03/13/24 at 11:59 am the Maintenance Manager said he went into all resident rooms and checked the water temperatures and confirmed that they were at temperatures of 110.1 and below. In an interview on 3-13-24 at 12:20 pm the SW was in-serviced on water temperatures. If the water is too high, over 110, she lets the maintenance director know. Hot water can harm elderly residents' skin because it is much more sensitive. The water can burn their hands. Their hands are more sensitive to the heat and could cause blisters. In an interview on 3-13-24 at 12:37 pm the ADON stated he was in-serviced recently by the corporate office and learned the temperatures should be between 100and not over 110 and thermostats should not be set higher than 110. If someone complains that water was hot to notify maintenance so water temperature can be checked. If a resident has redness or blistering they need to notify MD. It is important to have temperatures regulated to prevent burns. Because of residents' age group, their skin is more sensitive and need temperatures to be regulated. In an interview on 3-13-24 at 12:44 pm LVN P was in-serviced recently that discussed proper water temperatures. Water temperatures should be between 100 and 110 to prevent burns. The skin of the elderly is very fragile, and they can blister easily. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 3-13-24 at 12:49 pm Housekeeper R stated he was in-serviced about hot water and the need to report if a resident was burned. He should report to maintenance immediately if someone is burned because water temperature might be too high. Water temperatures in resident rooms should not be higher than 110. He has to be more particular about water temperature with the elderly because they have sensitive skin. In an interview on 3-13-24 at 1:01 pm CNA Q stated she was in-served about water temperature. The water should be 110 or lower. If she notices that resident has a blister or hot water burn, she should notify the nurse. If she notices that water temperature is too high, notify ADM and maintenance. Check water before residents come into contact with the water because they have sensitive skin like a baby. Sometimes residents react more slowly and that is a risk factor to being burned with hot water. In an interview on 3-13-24 at 1:05 PM CNA S stated she was in-serviced about water temperature. She said water should not be higher then 110, and should be 101 to 110 for residents. If the water was too hot they would have red spots on their body because they are more sensitive and if they see something like that, tell the nurse on duty. Residents are more susceptible to being burned because they get burned easier than younger people. In an interview on 3-13-24 at 1:29 pm LVN T stated she was in-serviced about the water temperatures in the facility. When they test the water temperature prior to resident going to shower, if it is too hot, notify management and maintenance. The temperature should not be above 110. This is important for the elderly because their skin is thinner and more fragile. In an interview on 3-13-24 at 1:13 PM CNA U stated she attended an in-service about hot water and if the resident gets burned. They discussed that the water temperature should be not over 110. If temperatures are over 110 the residents can get burns and blisters and sores. The skin of the elderly is softer and more tender so it is important that water temperature is not over 110. In an interview on 3-13-24 at 1:19 PM CNA E stated she was in-serviced about the water temperature. The water temperature should not be higher than 110 and if a resident gets scorched, report to the nurse. If she thinks the temperature is higher than 110 report to maintenance and the ADM. Residents' skin is not as tough as hers and residents' skin burns more easily. In an interview on 3-13-24 at 1:33 PM LVN W stated she was in-serviced about the temperature of water. When the resident complains about the temperature report immediately. The temperature of water should not be higher than 110. If she thinks the water is hotter tell the administrator and the maintenance person. The skin of the elderly was very thin and they can burn easily. In an interview on 3-13-24 at 1:37 pm LVN W -she was in-serviced recently. She said the water temperature should be 110 or below. If the water is too hot do not give resident a bath and notify maintenance. Because the residents are older, the hot water can burn their skin because their skin is thin. In an interview on 03/13/2024 at 3:26 pm the Resident in room [ROOM NUMBER] (where water temperature was too high), he said he did not receive any burns or injury from the water being too high. He said he knew how to adjust the water. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 3-13-24 at 3:33 pm COO stated she started the in-services and interviewed the regional nurse consultant and the AD. In the in-service she reviewed water temperature safety. They discussed that water temperatures can't be over 110. They discuss that the elderly have skin that is thinner and high water temperatures can harm the elderly. The elderly might have communication issues and not be able to communicate if the water is too hot. It is important to do skin checks if a resident is exposed to high water temperatures. They discussed how exposure to warm or hot water can affect the residents in the facility and how cognition and movement are involved when residents water temperature is too high. Reviewed the following inservices: 1. 1:1 in-service with Administrator on Water Temperature policy and Regional Nurse consultant 2. 1:1 in-service with Assistants Director of Nursing on Water temperature policy, reporting any concerns or complaints, including water temperatures to Administrator upon discovery, and on risk factors for scalding/burns in the elderly, signs and symptoms of burns, and changes in condition 3. Administrator in-services with Maintenance Director and IDT (Interdisciplinary team) water temperatures in residents' rooms, showers, and all resident accessible water sources to be below 110.1 and checking water temperatures daily 4. Assistant Director of Nursing/Designee in-services to staff on reporting any concerns or complaints regarding water temperatures to Maintenance Director or Administrator upon discovery. 5. Direct Care staff in-services by ADON/Designee on risk factors for scalding/burns in the elderly, signs and symptoms of burns, and changes in condition. 6. RNC in-service to ADONs on water temperature policy, reporting concerns or complaints including water temperatures to Administrator upon discovery, and on risk factors for scalding/burns in the elderly, signs and symptoms of burns, and changes in condition While the IJ was removed on 03/13/2024 the facility remained out of compliance at a severity level of no actual harm at a scope of pattern due to staff needing more time to monitor the plan of removal for effectiveness.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care, consistent with professional standards of practice for 2 (Resident #18 and #19) of 4 Residents reviewed for respiratory care. The facility failed to ensure that Resident #18's Nebulizer tubing and mouthpiece, which includes the nebulizing chamber (unit into which liquid medicine is converted into aerosol or mist by the pressurized air pumped through the tubing), were dated, bagged, and replaced every seven (7) days. The facility failed to ensure that Resident #19's Nebulizer tubing and mask were bagged and replaced every seven (7) days. The facility failed to ensure that the oxygen tubing for Resident #19 was dated and replaced every seven (7) days. The facility failed to ensure that the air filter for Resident #19's air concentrator was cleaned and free of debris. These failures could place residents at risk for respiratory discomfort, compromise, and infection. Findings included: Resident #18 Review of Resident #18's Face Sheet dated 02/22/2024 reflected an [AGE] year-old male admitted to the facility on [DATE], with a latest return date of 01/02/2024, and the following diagnosis: Sepsis (body's extreme response to an infection that [NAME] a chain reaction throughout the body), Chronic Obstructive Pulmonary Disease (COPD) (group of diseases that cause airflow blockage and breathing-related problems), Wheezing (high-pitched sound made while breathing and often associated with difficulty breathing). Review of Resident #18's MDS Quarterly Assessment, dated 11/17/2023 revealed Resident #18 had a BIMS Score of 15, which indicated cognition is intact. Review of Resident #18's Comprehensive Care Plan last reviewed on 01/28/2024 revealed no problem area for Oxygen / Nebulizer Treatment. Review of Resident 18's undated Consolidated Physician Orders reflected the following start dates / orders: 01/18/2024 for albuterol sulfate HFA aerosol inhaler; 90 mcg/actuation; amt: 2 puffs; inhalation Every 6 Hours - PRN, 01/17/2024 for albuterol sulfate solution for nebulization; 2.5 mg / 3 mL (0.083%); amt: 3 ml; inhalation Every 6 Hours PRN. Resident #18's orders did not reflect any order in reference to care of his nebulizer. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #18's Recent Progress Notes reflected entry on 01/18/2024 at 1:57 AM, Returned from hospital via ems on stretcher in stable condition. V/s 128/70, 71, 18, 97.4 spo2 97% ra no c/o pain voiced at this time. N.O received for Zithromax 500 mg prophylactic, albuterol 108/90 mcg inhaler prn sob. Np notified. Transferred to bed. Call light in easy reach. Fluids encouraged. Ongoing monitoring will continue. In an observation and interview on 02/20/2024 at 9:05 AM, Resident #18 was lying in his bed with a Nebulizer present on the night stand next to the bed. The Nebulizer had oxygen tubing connected to it that ran to a mouthpiece with nebulizing chamber that was on the floor under the head of Resident #18's bed. There was additional oxygen tubing present with nasal canula that was hanging off the nightstand's top drawer. None of the oxygen tubing was dated and neither the nasal cannula nor mouthpiece were bagged or dated. Resident #18 stated that he knew the mouthpiece was on the floor and had not used it recently but could not say how long it had been there. Observation on 02/21/2024 at 8:32 AM, Resident #18 was in his bed with the nebulizer present on the nightstand. The oxygen tubing with mouthpiece and nebulizing chamber were no longer present. The oxygen tubing with nasal canula was still present hanging on the nightstand drawer undated and not bagged. Observation on 02/22/2023 at 8:32 AM, Resident #18 was in his bed eating breakfast. The Nebulizer was still present on the nightstand with the undated / unbagged oxygen tubing and nasal canula. Resident #19 Review of Resident #19's Face Sheet dated 02/22/2024 reflected an [AGE] year-old female admitted to the facility on [DATE] with the following diagnosis: Acute Chronic Diastolic Heart Failure (condition in which the heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly), Acute Respiratory Failure with Hypoxia (low level of oxygen in the blood), Chronic Pulmonary Edema (condition in which too much fluid accumulates in the lungs, interfering with a person's ability to breathe normally), and Encephalopathy (damage or disease that affects the brain). Review of Resident #19's Comprehensive MDS Assessment, dated 02/03/2024 revealed Resident #19 had a BIMS Score of 11, which indicated moderate cognitive impairment. Review of Resident #19's Comprehensive Care Plan revealed a Problem edited 01/15/2024, Oxygen Therapy: [Resident #19] requires oxygen therapy related to Hypoxemia 3L o2 cont NC, Approach edited 08/01/2022, Change canula or mask and tubing as per facility protocol and prn. Review of Resident 19's undated Consolidated Physician Orders reflected the following start dates / orders: 11/09/2022 for Continues oxygen via nasal canula to keep oxygen above 92 Every Shift, Change O2 humidifier water, tubing, and mask Q week on Sunday, and Keep O2 tubing and mask bagged / covered when not in use. 11/15/2023 for albuterol sulfate HFA aerosol inhaler; 90 mcg/actuation; amt: 2 Puffs; inhalation Every 4 hours - PRN. 08/08/2023 for Change nebulizer tubing every week on Sunday Once a Day on Sun Night. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's TAR from 12/03/2024 - 02/18/2024 as it related to Change O2 humidifier water, tubing, and mask Q week on Sunday. Once a Day on Sun Night 18:00 (6:00 PM) - 06:00 (6:00 AM) reflected that the task had been completed recently on 02/18/2024 at 8:40 PM by LVN I and on 02/11/2024 at 7:07 PM. In an observation and interview on 02/20/2024 at 10:40 AM, Resident #19 was seated in her motorized wheelchair receiving oxygen via nasal canula from an air concentrator plugged into the room's electrical outlet. The concentrator displayed an oxygen distribution level of 4L per minute. The air filter on the concentrator was completely covered in a grey substance that was soft to the touch. The concentrator had a humidifier bottle attached that was not dated and none of the attached tubing was dated. On a dresser beside the concentrator was a nebulizer with oxygen tubing that was not dated and connected to a mask. The mask was not in a bag and displayed a date of 2/11/24 on the side of it. Resident #19 stated that she was continuously on oxygen and does use the nebulizer. Resident #19 stated that staff attempt to change out the tubing weekly, but it is expensive. Resident #19 apologized and stated that she normally cleans the filter on her concentrator and had not done so lately. Observation on 02/22/2023 at 8:35 AM, Resident #19 was seated in her motorized wheelchair receiving oxygen via nasal canula through air concentrator. The humidifier bottle and tubing were not dated, and the nebulizer mask was not bagged and still displayed the date of 02/11/2024. Interview on 02/22/2024 at 9:47 AM with Resident #19's HOSPICE RN. HOSPICE RN stated that she would like to see Resident #19's oxygen tubing changed, dated, and air filter cleaned weekly. HOSPICE RN stated that failure to do so could result in a respiratory infection. In an observation and interview on 02/22/2023 at 10:11 AM, LVN E stated that oxygen tubing was to be changed out weekly by the Sunday night LVN. LVN E stated that nebulizer mask were supposed to be dated on the side when they are changed. LVN E stated that oxygen tubing should be dated as well because failure to do so could result in uncertainty about how long it has been there. LVN E entered the room of Resident #18 and stated that the tubing should be dated and picked it up to show that it was not connected to the nebulizer. LVN E stated that she observed the nebulizer mouthpiece with chamber on the floor of Resident #18's room and removed it on 02/21/2024. LVN E stated that failure to properly change and date oxygen tubing and nebulizer mask could result in respiratory infection. In an observation and interview on 02/22/2023 at 10:22 AM, the ADON stated that oxygen tubing and mask changes are set by order but stated they are usually completed every Sunday by the nighttime LVN. The ADON stated that air filters are to be checked when mask and tubing are changed out and should be cleaned if dirty. The ADON stated that oxygen tubing should be dated. The ADON stated that failure to properly change and date oxygen tubing and mask could result in respiratory infection. At 10:27 AM, the ADON entered the room of Resident #19 and checked her respiratory care equipment. The ADON stated that the nebulizer mask was past date and was supposed to be bagged. ADON stated that the mask should have been changed and the oxygen tubing dated. The filter for the concentrator was now clean and Resident #19 stated that she cleaned it herself. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/22/2023 at 11:10 AM, the Nurse Consultant stated that they do not date tubing but that they do change it out every Sunday. The Nurse Consultant stated that the concentrator's air filter should be checked and cleaned every Sunday night along with the tubing. The Nurse Consultant was asked if they date nebulizer mask and she stated they do not. The Nurse Consultant was questioned how they could be certain that the tubing and mask were being changed every Sunday if nothing was dated. The Nurse Consultant stated they log the change in their Administration Record and requested the name of the resident. The Nurse Consultant reviewed the TAR for Resident #19 and turned the screen to displayed that it was completed by LVN I on 02/18/2024. The Nurse Consultant viewed images of the dated nebulizer mask and dirty filter and stated that mask was obviously not changed on 02/18/2024 and further stated that the filter was not cleaned recently either. The Nurse Consultant stated that failure to change out oxygen tubing and mask could result in respiratory issues for residents. In an interview on 02/22/2024 at 11:34 AM, The ADON advised that LVN I was not available for an interview due to her working on the night shift. In an interview on 02/22/2024 at 12:12 PM, the Nurse Consultant stated that she did review the TAR for Resident #18's nebulizer care and stated that there were no records or documentation of tubing or mouthpiece changes. Review of the facility's Respiratory Therapy - Prevention of Infection Policy dated November 2011, reflected, Purpose - The Purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Steps in the Procedure - Infection Control Considerations Related to Oxygen Administration 1. Obtain equipment (i.e , oxygen tubing, reservoir, and distilled water). 2. Use distilled water for humidification per facility protocol. 3. [NAME] bottle with date and initials upon opening and discard after twenty-four (24) hours. 7. Change the oxygen canula and tubing every seven (7) days, or as needed. 8. Keep the oxygen canula and tubing used PRN in a plastic bag when not in use. 9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. Infection Control Considerations Related to Medication Nebulizers / Continuous Aerosol: 7. Store the circuit in plastic bag between uses. 9. Discard the administration set up every seven (7) days. Documentation - The following information should be recorded in the resident's medical record: 1. The date and time the respiratory therapy was performed. 2. The type of respiratory therapy performed. 3. The name and title of the individual(s) who performed the respiratory therapy. 48314

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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. 28689 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable for 1 (Pod 2 medication storage room) of 2 medication storage rooms, 1 (Pod 2 medication cart) of 1 medication carts and 1 (Pod 2 treatment cart) of 1 nurse treatment carts. The facility failed to ensure three medications (total of 5 bottles) were not past their expiration dates in the Pod 2 medication storage room. The facility failed to ensure two medications were not expired in the Medication Aide cart on Pod 2. The facility failed to ensure one bottle of aspirin was not expired in the nurse treatment cart on Pod 2. These failures could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings included: Observation on 02/21/2024 at 9:00 AM in the Pod 2 medication storage room revealed 2 bottles of Naproxen (pain reliever) with expiration dates of 12/2023, 2 bottles of CoQ 10 - 100 mg (supplement) with expiration dates 12/2023, and a bottle of Renavite (vitamin) with an expiration date of 12/2023. In an interview on 02/21/2024 at 9:05 AM LVN B stated she was an agency nurse and did not know what the facility policy was regarding who is supposed to check the carts or storage rooms for expired medications. She stated expired medications would not be as effective and not as potent. Observation and interview on 02/21/2024 at 9:09 AM of the nurse treatment cart on Pod 2 revealed a bottle of ASA 325 mg (aspirin - pain reliever) with an expiration date of 01/2024. LVN B stated she thought the night nurses were supposed to be auditing the carts. Observation on 02/21/2024 at 9:16 AM of the medication aide cart on Pod 2 revealed a bottle of Naproxen with an expiration date of 05/2023 and Dairy Aid with an expiration date of 09/2023. In an interview on 02/21/2024 at 9:23 AM MA H stated she had not received any formal training on keeping the carts free of expired medications, but the ADON asked her 3-4 weeks ago to go through her cart. She was unsure about any policies regarding expired medications. She stated it was everyone's responsibility to keep the carts free of expired medications. She further stated the expired medications would not have the efficacy and could have a diminished therapeutic level. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/22/2024 at 2:29 PM the ADON stated the nurses are responsible first and then the ADON for checking and ensuring that medications are not expired. She stated the potential risk to the resident is that the drug would potentially not be strong enough to treat the condition.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48314 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen reviewed for sanitation. The facility failed to discard of food products that were past the use by date in the dry storage area. The facility failed to discard of a food product that was past the use by date in their double door refrigerator. The facility failed to store boxes off the floor in the walk-in-freezer. These failures could place residents at risk of cross contamination and foodborne illness. Findings included: Observation on [DATE] at 6:53 AM revealed that the dry food storage area contained the following expired food products on the shelf: 19 twelve-ounce cans of evaporated milk with a displayed use by date of [DATE], 5 forty-eight-ounce containers of prune juice dated [DATE] with a displayed use by date of [DATE], and 1 forty-six-ounce container of prune juice dated [DATE] with a displayed use by date of [DATE]. Observation on [DATE] at 7:04 AM of the facility's walk-in freezer revealed two stacks of food product boxes on the floor. In an interview and observation on [DATE] at 7:15 PM, the Dietary Manager stated that the 6 total containers of outdated prune juice should not have been on the shelf and should have been discarded. The Dietary Manager stated that the 19 cans of evaporated milk should not have been on the shelf and should have been discarded. The Dietary Manager stated that they use the evaporated milk and prune juice seldomly, but that dietary staff should be regularly checking dates and discarding expired food products. The Dietary Manager stated that use of expired / out of date food products could result in contamination and food borne illness. The Dietary Manager stated that the two stacks of food product boxes in the walk-in freezer were there because they were delivered [DATE] at approximately 5:30 AM. The Dietary Manager stated that there is not supposed to be anything on the floor in the freezer. Observation on [DATE] at 7:23 AM of the facility's double door refrigerator revealed an open forty-eight-ounce container of prune juice that was dated [DATE] with a displayed use by date of [DATE]. In an interview on [DATE] at 11:08 AM, the Dietitian stated that food products in the kitchen are to be checked regularly and expired items are to be discarded. The Dietitian stated that serving food products consumed after their use by date could result in food borne illnesses. The Dietitian stated that no food products should be stored on the floor anywhere in the kitchen but may have to be for a short period of time when first received. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 11:49 AM, Cook K stated that all food products should be dated and removed when they are past the facility or manufacture use by date. Cook K stated that they are supposed to check dates at least once a week. Cook K stated that failure to do so could result in food poisoning. Review of the facility's Dietary Services Policy and Procedure Manual dated [DATE] for Food Receiving and Storage reflected, Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Dry Storage 4. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. Foods Kept Away From the Floor 5. Food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents. Dry Foods Stored in Bins 6. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in - first out system. Labeling Foods Stored in Refrigerator/Freezer 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). The facility's policy does not address storage of food products or boxes on refrigerator / freezer floors and does not specifically address use by dates for dry storage food products on shelves. Review of facility In-service Record dated [DATE] presented by the Dietary Manager for Topic/Unit: Closing Cook Check, AM Cook Check revealed, *Closing cook must check cook's fridge and freezer as well as walk-in coolers *What you must check for: Any item out of date, label and date on all items, food that does not look fresh, all bagged items are sealed with what the contents are and date. *The closing cook is the inspector, and the morning cook is the safety net. Nothing should slip by!!! *The morning cook should check all the coolers first thing in the morning.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. 48314 Based on interview and record review, the facility failed to establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that take into account nonsmoking residents for one of one facility reviewed for smoking. The facility failed to develop a policy to address residents within the facility that were smokers. The facility failed to develop a policy to address smoking materials possessed by residents who are known smokers within the facility. The facility failed to notify residents in writing during admission that it is a no smoking facility and address options for smokers. These failures could place residents at risk for injury, burns, and an unsafe smoking environment. Findings Include: Interview on 02/21/2024 at 8:00 AM, the RN Consultant was requested to provide their policy in reference to smoking. The RN Consultant advised that she did not believe they had one because they are a no smoking facility. Interview on 02/21/2024 at 8:08 AM, the ADMINISTRATOR stated that they do not have a smoking policy because they are a no smoking facility. The ADMINISTRATOR was requested to provide a policy in reference to smoking materials, such as cigarettes and lighters, and stated they do not have one. The ADMINISTRATOR stated that residents who do smoke have smoking assessments and have the capabilities to ensure their safety as well as securement of their smoking materials. Interview on 02/22/2024 at 2:19 PM, the ADMINISTRATOR was requested to provide any rules or guidelines that residents are provided upon or after admission in reference to smoking. The ADMINISTRATOR stated that she did not believe there was anything, but that the surveyor would need to check with Admissions. Interview and observation on 02/22/2024 at 2:40 PM, the ADON stated that she knew rules had been provided at one time to smoking residents and that they were securing smoking materials towards the end of 2023 but that was discontinued. The ADON stated that residents maintaining their own smoking materials could pose a fire risk, especially if used in areas with oxygen. The ADON was asked if they had any smoking materials in the area of the nurse's station, which she checked, and none were located. The ADON then checked the secured medication storage room and located an open pack of cigarettes in a sealable plastic bag that had no information on it. The ADON stated that the cigarettes were possibly taken from a resident who was not supposed to have them but could not state for sure how they came to be in the medication storage area. The ADON stated that she was not sure if they have a smoking policy but stated they should have a policy if they don't. Interview on 02/22/2024 at 4:03 PM, the Receptionist stated that she does not hold cigarettes or lighters for residents behind the front desk counter. The Receptionist stated that residents are to sign themselves out and go off property to smoke if they want to do so. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/22/2024 at 5:30 PM, the Admissions Coordinator stated that she did speak with the Administrator in reference to smoking residents and reviewed their entire admission packet. The Admissions Coordinator stated that there is nothing in their packet that addresses smoking. The Admissions Coordinator stated that they do discuss with the residents and their families that they will have to go off property if they want to smoke. Review of resident roster provided by the Administrator on 02/20/2024 at 9:40 AM displayed a key indicating Smokers with a dot by their name. Review revealed that the facility identified 9 Residents as smokers. Review of the facility's ADMISSION AGREEMENT dated July 2023 revealed no information in reference to whether it was a smoking or non-smoking facility. The agreement further did not address any policies or guidelines for a resident who is a smoker.