STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676476	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights on Valley Ranch	23200 Valley Ranch Parkway Porter, TX 77365

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on interviews and record reviews, the facility failed to recognize the residents right to formulate an advance directive for 1 of 20 residents (Resident #264) reviewed for advanced directives. The facility failed to enter a code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) for Resident #264 from admission on 3/6/24 to 3/21/24. This failure could place residents at risk of not having their end of life wishes met. Findings include: Record review of Resident #264's face sheet printed 3/19/24 at 2:54pm, revealed she was a [AGE] year-old female admitted on [DATE] with diagnoses of fracture of left femur, fracture of left wrist, wedge compression fracture of lumbar vertebrae, fracture of left forearm, dyspnea (shortness of breath), acute kidney failure (kidneys are not filtering correctly), type 2 diabetes (body does not produce enough insulin), and dementia. Under Advance Directive on the care plan, it was blank. Record review of Resident #264's Entry MDS assessment dated [DATE] revealed she admitted to the facility on [DATE] from a hospital. Record review of Resident #264's BIMs score performed by the SW on 3/7/24 at 4:21pm, revealed she had severely impaired cognition. Record review of Resident #264's care plan dated 3/7/24, revealed a Focus: Resident/Family/RP does not have advanced directives and elects Full Code Status (Initiated: 3/7/24, Created: 3/7/24). Goal: Community will follow full code status (resuscitation provided when the heart stops) through review date (Initiated: 3/7/24, Created: 3/7/24, Target: 6/5/24). Interventions: Review code status at least annually and as indicated (Initiated: 3/7/24, Created: 3/7/24). Record review of Resident #264's medical record revealed a Care Plan Conference note from 3/8/24 at 11:41am from the SW. The note revealed the resident's family member decided they wanted the resident to be a full code. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #264's active Physician Orders by MD A on 3/19/24 at 2:52pm, revealed no orders for a code status. Record review of Resident #264's Physician Orders by MD A revealed an order from 3/21/24 at 10:23am which revealed, Full Code Clarification Order. In an interview with the SW on 3/21/24 at 9:38am, she said Staff A should have put the code status in for Resident #264 when she received the admission papers for the resident. She stated she updated the care plans once admissions entered the code status for the resident. She said the nursing staff and all staff should have caught the issue and she did not know why it was not caught. She said she would investigate the issue that she had the care plan meeting, which said the resident wanted to be full code, but nothing was entered into the chart after that. In an interview with Staff A on 3/21/24 at 9:47am, she said nursing received all the admission papers from the hospital regarding code status and entered the code status. She said she was medical records and did not receive admission papers prior to the resident coming to the facility. She said admissions would be the person who would receive the paperwork before the resident arrived. In an interview with the Admissions Director on 3/21/24 at 9:51am, she said she received all the admission papers from the hospital before residents arrived. She then filled out a paper that indicated if the resident wanted to be a full code or DNR. She said then the SW had the care plan meeting and confirmed with the family/resident if the code status was correct, or if they wanted to change it. She said after the SW confirms the code status, she updated the face sheet. As far as entering the code status order, she thought nursing was responsible for that, but she was unsure. Regarding Resident #264, she said she received admission papers that the resident wanted to be a full code and had filled out the necessary papers. She said she performed all of her job duties and it was next in the hands of the SW. In an interview with the DON on 3/21/24 at 10:16am, she said the nursing staff would have received the admission papers for Resident #264 before she arrived at the facility. The nursing staff were responsible for updating the face sheet and entering a code status on the resident. She said she was unsure of why it was not done, and she would have to talk to the nurse. She said if a code status was not entered on a resident, they would perform full code until told otherwise. Record review of the facility's policy and procedure for Advanced Directives (revised January 2023) read in part: Every resident has the right to formulate an advance directive and to refuse treatment. The community will determine the existence of an advance directive at the time of admission .The IDT will notify the medical provider of the resident's/representative's care decisions made to include expressed advance directive, such as DNR code status. The nurse should then obtain a physician's order for appropriate care decision in order to initiate and implement the preferred treatment wishes expressed .The medical record and resident plan of care should reflect the resident's wishes as well as the physician orders in order to meet the directives described.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights for 3 of 6 residents (Resident #24, Resident # 40, and Resident #213) reviewed for care plans. -Resident #24's care plan reflected she had a DNR status despite having orders to be full-code (desiring resuscitation if the heart stops) . -Resident #40's and Resident #213's care plans reflected they were a full-code status despite having orders and an active DNR on file. These failures could lead to confusion related to life saving measures, life saving measures being provided to a resident who had a DNR status, not providing life saving measures to a resident who had a full-code status. Findings included: Resident #24 Record review of Resident #24's face sheet dated 3/19/2024 revealed a [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included spinal stenosis (condition where spinal column narrows and compresses the spinal cord), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), polyneuropathy (damage to multiple peripheral nerves), scoliosis (condition characterized by sideways curvature of the spine or back bone, often noted during growth spurt just before a child attains puberty), and dementia (group of symptoms that affects memory, thinking and interferes with daily life). Record review of Resident #24's quarterly MDS assessment dated [DATE] with an ARD of 2/28/2024 revealed a BIMS score of 3 indicating severe impairment. The MDS documented she had no impairment of either her upper or lower extremities, and she used a wheelchair for mobility. Per the MDS, Resident #24 required assistance with all ADLs except eating. The MDS revealed she was not receiving hospice care services. Record review of Resident #24's care plan dated 2/22/2024 revealed a focus on her DNR status. Record review of Resident #24's physician's orders report dated 3/19/2024 revealed an order dated 1/16/2024 for her to have a full code status. Resident #40 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #40's face sheet dated 3/19/2024 revealed a [AGE] year-old man admitted on [DATE]. The face sheet documented his diagnoses included acute hematogenous osteomyelitis (infection in the bone caused by bacteria or fungi) of the foot and ankle, muscle wasting (loss of muscle leading to its shrinking and weakening) and atrophy (thinning of muscle mass), type 2 diabetes mellitus (condition results from insufficient production of insulin, causing high blood sugar), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (group of mental illnesses that cause constant fear and worry), neuropathy (group of diseases resulting from damaged or malfunctioning of nerves that causes weakness, numbness and pain in hands and feet), hypertension (high blood pressure), heart failure (condition in which the heart has lost the ability to pump enough blood to the body's tissues), COPD (common and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), GERD (chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach), diverticulitis (inflammation of the diverticula, small, bulging pouches that can form in the lining of the digestive system), benign prostatic hyperplasia (condition in which the flow of urine is blocked due to the enlargement of prostate gland), and acquired absence (amputation) of the foot. Record review of Resident #40's quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating no cognitive impairment. The MDS documented he had no impairment of either his upper or lower extremities, and he used a wheelchair for mobility. Per the MDS, Resident #40 required assistance with toileting, bathing, dressing his lower body, putting on and/or taking off footwear, and personal hygiene. Record review of Resident #40's care plan dated 2/15/2024 revealed a focus on his self-care deficit with interventions including assistance with bed mobility, dressing and grooming, hygiene, toileting, and transfers. The care plan revealed he did not have advanced directives in place and elected to be full code. Record review of Resident #40's DNR dated 8/31/2023 revealed it was signed by Resident #40, two witnesses, and his PCP on 8/31/2023. Record review of Resident #40's physician's orders report dated 3/19/2024 revealed an order for him to have a DNR status dated 9/8/2023. Attempted interview on 3/21/2024 at 1:24 PM with Resident #40 was unsuccessful as he refused. Attempted interview on 3/21/2024 at 3:35 PM with Resident #40 was unsuccessful as he was not in his room. Resident #213 Record review or Resident #213's face sheet revealed a [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included a pelvis (basin-shaped complex of bones that connects the trunk and the legs, supports and balances the trunk, and contains and supports the intestines, the urinary bladder, and the internal sex organs) fracture (partial or complete break in a bone), fracture of the pubis (most forward-facing bone of the pelvic bones), fracture of the fourth lumbar vertebra (bone in the lower back), hypertension (high blood pressure), and dementia (group of symptoms that affects memory, thinking and interferes with daily life). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #213's admission MDS assessment dated [DATE] with an ARD of 2/8/2024 revealed a BIMS score of 13 indicating no cognitive impairment. The MDS documented she had no impairment of either her upper or lower extremities, and she used a wheelchair for mobility. Per the MDS, Resident #213 required assistance with all ADLs except eating and personal hygiene. Record review of Resident #213's care plan dated 3/16/2024 revealed she did not have advanced directives and elected to be full code. Record review of Resident #213's DNR form dated 3/8/2024 revealed it was signed by Resident #213, two witnesses, and the physician on 3/8/2024. Record review of Resident #213's physician's orders report dated 3/19/2024 revealed an order for her to have a DNR status. Interview on 3/21/2024 at 1:09 PM with Resident #213, she said she did not recall going over any paperwork when she first admitted to the facility. Resident #213 said she did not remember speaking to anyone about her advanced directives. Resident #213 said she would not want to have life saving measures provided if she required them. Interview on 3/21/2024 at 9:21 AM with the Corporate MDS Nurse, she said she was responsible for providing supervision to the MDS nurses at multiple facilities within the corporation. The Corporate MDS Nurse said updating the care plans was a system approach. The Corporate MDS Nurse said the nurse responsible for a specific area would update that care plan area, such as the nurse responsible for weights would update a resident's weight care plans. The Corporate MDS Nurse said advanced directives were typically completed by the social services department. The Corporate MDS Nurse said Resident #40's care plan was incorrect related to his DNR status. The corporate nurse said typically the social services director would update the care plan as soon as the DNR order was received from the resident's PCP. The corporate nurse said Resident #40's care plan documented he was a full-code resident, but he had an active DNR, had a DNR order, and the care plan should have reflected that. The Corporate MDS Nurse said care plan reflected her DNR on file, but the electronic medical record documented she was full code. The Corporate MDS Nurse said if a resident's advanced directives were incorrect it could lead to a miscommunication and staff either performing life saving measures on a resident who was DNR, or not providing life saving measures to a resident who was full code. Interview on 3/21/2024 at 9:29 AM with the SW, she said she had been employed for seven years. The SW said she was not responsible for updating resident care plans. The SW said she was not sure why Resident #40's care plan documented he had a full code status. The SW said Resident #40 had a DNR status. The SW said Resident #24 had gone to the hospital multiple times since her admission and her DNR or full code status may have been missed in the system. The SW said when a resident first admitted , if he/she did not have a DNR in place and wanted to do so she would complete it then. The SW said medical records would then send the DNR to the resident's PCP for signature. The SW said a resident would remain in full code status until the DNR order was received from the physician. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/21/2024 at 10:09 AM with the DON, she said the facility had called Resident #24's RP on 3/21/2024 and the family member was confused on what a DNR entailed. The DON said Resident #24 had gone to the hospital three times since her initial DNR was put in place, and that Resident #24's RP did not understand what the difference between DNR and full code status was. The DON said Resident #24's RP had requested the facility call her prior to any life saving measures, or to send her to the hospital for life saving measures. The DON said Resident #24's RP agreed to have Resident #24 have a full code status. The DON said Resident #24's care plan was incorrect. The DON said if a resident did not have any documentation in the DNR binder, that resident was in a full code status. The DON said the facility would perform life saving measures for any resident who was full code status. The DON said the facility would complete an audit to ensure all the residents' care plans were correct regarding their advanced directives. The DON said if the resident's care plan was incorrect and noted he/she was in a full code status, the facility may begin life saving measures, but that would not be as concerning as not providing life saving measures to a resident who had a full code status. The DON said if the facility did not initiate life saving measures for a resident with a full code status, that resident could die. Interview on 3/21/2024 at 2:40 PM with the ADON, she said she had been employed since December of 2023. The ADON said her primary duties included caring for residents, advocating for residents, ensuring they were well cared for, medication administration, and assistance with ADLs. The ADON said care plans were put in place to identify a resident's care needs. The ADON said the care plans were instructions on how to care for a resident. The ADON said she would review the care plans when she had a concern for a resident. The ADON said if there were two different instructions in the care plan versus the physician's orders, she would look at order first. The ADON said if a resident was wrongly identified as having a full code status and life saving measures were provided to a resident with a DNR status, the facility or staff could be liable for damages. Interview on 3/21/2024 at 2:59 PM with the WCN, she said he had been employed since December 7, 2023. The WCN said her primary duties were to care for the residents' wounds in the building. The WCN said she was the facility's wound care nurse. The WCN said the residents' care plans provided a plan of care, or how to care for a resident at the facility. If a care plan was incorrect the resident may not receive the care he/she required. Interview on 3/21/2024 at 3:59 PM with the Admin, he said he had been employed since February 2023. The admin said his expectations related to residents' care plans were that they would ideally be completed by the IDT system. The Admin said in past communities he was employed at, the facilities would complete generalized resident care plans. The Admin said he would like for the facility to create more individualized resident care plans. The Admin said resident care plans were reviewed during the morning meetings and were completed as the IDT was able during those meetings. The Admin said his expectations for resident care plans was that they were individualized. The Admin said if a care plan did not match a resident's physician's orders, the resident may not be provided care as was ordered. The Admin said the facility ensured the physician's orders were reflected in the electronic medical record first, and then the facility would update the resident's care plan. Record review of the facility's Code Status binder revealed Resident #40's DNR was present, Resident #213's DNR was present, and Resident #24 did not have a DNR present. The binder had a list of all residents with a DNR status. Resident #40 and Resident #213 were identified as having a DNR in place, but Resident #24 was not. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Care Plans policy dated February 2023 revealed a policy statement which read in part .The community develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment . The policy documented the care plan would include any services that would not be provided due to the resident's exercise of rights, including the right to refuse treatment. Per the policy, residents had the right to refuse specific treatments. The policy noted the care plan would be updated within seven days of the completion of the comprehensive assessment. Record review of the facility's Advanced Directives policy dated January 2023 revealed a policy statement which read Every resident has the right to formulate an advance directive and to refuse treatment. The community will determine the existence of an advance directive at the time of admission. The policy documented that a resident's medical record and resident plan of care should reflect the resident's wishes as well as the physician orders.

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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** 47722 Based on observations, interviews, and record reviews, the facility failed to ensure residents who were unable to carry out activities of daily living were provided with the necessary services to maintain good personal hygiene for 1 of 20 (Resident #48) residents sampled for ADL care. -The facility failed to provide Resident #42 with a specialized call bell between 3/19/24 and 3/21/24. -The facility failed to shower and dress Resident #42 in his own clothes between 3/19/24 and 3/21/4. -The facility failed to get Resident #42 up out of bed between 3/19/24 and 3/21/24. These failures could place residents who are dependent on staff for ADLs, at risk of not receiving personal hygiene, experiencing a delay in receiving necessary careb. Findings included: Record review of Resident #42's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with an original admitted [DATE]. He had diagnoses of anoxic brain damage (brain damage from lack of oxygen), chronic heart failure (heart does not pump strongly), gastrostomy (tube into stomach for nutrition), dysphagia (unable to swallow), aphasia (unable to talk), hypertension (high blood pressure), GERD, duodenal ulcer (ulcer in the small intestine), and muscle weakness. Record review of Resident #42's Annual MDS assessment dated [DATE], revealed a BIMS was not able to be conducted. The staff assessment for mental status revealed the resident had severely impaired cognition. The resident had impairment on both sides of his upper and lower extremities. According to the MDS, the resident was dependent with all ADLs. The resident was high risk for pressure ulcers/injuries but did not have any. The MDS revealed he was receiving applications of ointments/medications other than to feet and applications of nonsurgical dressings other than to feet. He was receiving tracheostomy care while a resident. (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 #42's care plan dated 2/13/20, revealed a Focus: Resident to use Geri Chair when out of bed d/t poor trunk control (Initiated: 8/2/21, Created: 8/2/21, Revised: 4/16/22). Goal: Resident to tolerate Geri chair through next review date (Initiated: 8/2/21, Created: 8/2/21, Revised: 1/17/24). Interventions: Staff to monitor resident for safety while in Geri chair. Staff to place resident in Geri chair when out of bed for safety. Focus: The resident uses a specialized call light: Blow light (Initiated: 1/20/21, Created: 1/20/21, Revised: 1/20/21). Goal: Resident will be able to utilize my call light without noted decline; to alert care providers of my needs and wants through my next review date (Initiated: 1/20/21, Created: 1/20/21, Revised: 1/17/24). Interventions: Provide a whistle - mouth blow type call light. Round regularly to ensure needs are met. Focus: I have a self care deficit r/t cognitive impairment, poor physical functioning, incontinent of bowel and bladder (Initiated: 6/29/23, Created: 12/30/21, Revised: 6/29/23). Goal: I will maintain or improve my ability to participate in my care with ADLs through my next review date (Initiated: 12/30/21, Created: 12/30/21, Revised: 1/17/24). Interventions: Bathing/showering schedule: I prefer to be showered 2-3 times weekly & as needed. Bathing/showering care: x 2 person assistance. Bed mobility: x 2 person assistance. Dressing & grooming: x 2 person assistance. Hygiene: I require 1 staff assist for hygiene ADLs. Off-loading device: I use pressure relieving boots/devices as indicated. Toileting/incontinent care x 2 person assistance. Total lift sling size: Large/green. Total lift x 2 team members. Transfers: x 2 person assistance with Hoyer Lift. Turning & Repositioning: On rounds and as needed. Focus: The resident has a potential to skin integrity r/t needing assistance with bed mobility and incontinence of bowel and bladder (Initiated: 2/27/20, Created: 2/27/20, Revised: 2/27/20). Goal: Resident will be free from injury to skin through the review date (Initiated: 2/27/20, Created: 2/27/20, Revised: 1/17/24). Interventions: Keep skin clean and dry. Use lotion on dry skin. Record review of Resident #42's Physician Orders revealed the following orders from MD A: -Heel protectors or float heels on pillow while in bed, every shift. Ordered on 7/23/23. -The patient out of bed can be in a Geri chair. Ordered on 9/14/21. In an observation of Resident #42 on 3/19/24 at 1:44pm, the resident was laying flat on his back in bed. He was in a patient gown, was not shaved, and his hair looked greasy. He had a regular call bell pinned to the sheets and his feet were not in heel protectors or floated on pillows. In an observation of Resident #42 on 3/20/24 at 10:16am, he was laying flat on his back in bed. He had a patient gown on, was not shaved, and his hair looked greasy. He had a regular call bell pinned to the sheets and his feet were not in heel protectors or floated on pillows. In an interview with Resident #42's family member on 3/20/24 at 10:20am, she said she would come to the facility every weekend to see him. When she came, he would not be shaved, bathed, his hair was greasy, and his ears were dirty. She said she would have to clean him every weekend when she came. She said she has not been able to come for a couple months due to being sick. In an observation of Resident #42 on 3/20/24 at 3:21pm, he was laying flat on his back in bed. He had a patient gown on, was not shaved, and had greasy looking hair. He also had a regular call bell instead of a special one and his feet were not in heel protectors or floated on pillows. (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 observation and interview of Resident #42 on 3/20/24 at 3:21pm, he was laying flat on his back in bed. He had a patient gown on, was not shaved, and had greasy looking hair. He also had a regular call bell instead of a special one and his feet were not in heel protectors or floated on pillows. The DON said she did not know why he was not shaved or had his special call bell. She said he would be cleaned up for tomorrow. In an observation of Resident #42 on 3/21/24 at 11:05am, he was up in a Geri chair in the activity room. He had heel protectors on, was shaved, had clean hair, and was in his normal clothes. In an interview with LVN C on 3/21/24 at 11:10am, she said she had given Resident #42 a bed bath a few days before and did not know why he was not shaved or up in his Geri chair. In an interview with the DON on 3/21/24 at 1:30pm, she said she ensured the staff were implementing the resident's interventions by making rounds throughout the day. She said the ADON and the floor nurses made rounds as well to ensure the interventions were in place. Record review of the facility's policy and procedure on Routine Resident Care (revised January 2023) read in part: Residents should receive the necessary assistance to maintain good grooming and personal/oral hygiene. Steps are taken to provide that a resident's capacity for self-performance of these activities does not diminish unless circumstances of the resident's clinical condition demonstrate the decline is unavoidable. Care is taken to maintain resident safety at all times. Licensed nurses and non-licensed direct care team members: .Showers, tub baths, and/or shampoos should be scheduled at least twice weekly and more often as needed or per residents' preferences .Daily personal hygiene minimally includes assisting .with washing their faces and hands and combing their hair. Residents should be encouraged or assisted to dress in appropriate clothing daily .Specific types of call lights, i.e. call light pads etc. should be added to the resident plan of care based upon residents abilities and limitations .

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	676476	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights on Valley Ranch	23200 Valley Ranch Parkway Porter, TX 77365

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #42) of 20 residents reviewed for quality of care. - The facility failed to treat Resident #42's wounds to his shins with available ointment that was prescribed. - The facility failed to treat Resident #42's tracheostomy stoma as directed by the Physician Orders. This failure could place residents at risk for diminished quality of care, pain, infection, and worsening conditions. Findings included: Record review of Resident #42's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with an original admitted [DATE]. He had diagnoses of anoxic brain damage (brain damage from lack of oxygen), chronic heart failure (heart does not pump strongly), gastrostomy (tube into stomach for nutrition), dysphagia (unable to swallow), aphasia (unable to talk), hypertension (high blood pressure), GERD, duodenal ulcer (ulcer in the small intestine), and muscle weakness. Record review of Resident #42's Annual MDS assessment dated [DATE], revealed a BIMS was not able to be conducted. The staff assessment for mental status revealed the resident had severely impaired cognition. The resident had impairment on both sides of his upper and lower extremities. According to the MDS, the resident was dependent with all ADLs. The resident was high risk for pressure ulcers/injuries but did not have any. The MDS revealed he was receiving applications of ointments/medications other than to feet and applications of nonsurgical dressings other than to feet. He was receiving tracheostomy care while a resident. Record review of Resident #42's care plan dated 2/13/20, revealed a Focus: Resident has an old tracheostomy site which requires daily dressing changes (Initiated: 8/26/22, Created: 9/17/22, Revised: 9/17/22). Goal: Will have no s/sx of infection through the review date (Initiated: 8/26/22, Created: 9/17/22, Revised: 1/17/24). Interventions: Treatment as ordered. Focus: I have risk for complications r/t tracheostomy stoma (opening where tube into throat was) site causing a risk for complications or SOB (Initiated: 12/30/21, Created: 12/30/21, Revised: 4/16/22). Goal: I will have clear and equal breath sounds bilaterally through the review date (Initiated: 12/30/21, Created: 12/30/21, Revised: 1/17/24). Interventions: Provide good oral care daily and PRN. Focus: Resident has a potential for alteration in skin integrity r/t friction, immobility, and contractures (Initiated: 10/18/22, Created: 10/18/22, Revised: 10/18/22). Goal: I will maintain skin integrity through next review date (Initiated: 10/18/22, Created: 10/18/22, Revised: 1/17/24). Interventions: Observe skin while providing care, report to nurse any skin concerns noted. Take extra care when transferring, skin is fragile, use palms of hands for support when able. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #42's Skin and Wound Evaluation from 2/20/24 at 3:03pm, revealed the resident had a surgical incision that was present on admission and was healed. There was no mention of the wounds to both of his shins. Record review of Resident #42's progress notes revealed a note from 3/10/24 at 7:57pm from NP A which said, Cleanse trach stoma site with SNS and cotton swabs. Dry the site and cover with gauze and tape. Monitor s/s of infection and skin integrity. Record review of Resident #42's Skin & Wound-Total Body Skin Assessment from 3/12/24 at 6:40pm, revealed there were no wounds. Record review of Resident #42's Skin & Wound-Total Body Skin Assessment from 3/19/24 at 11:56pm, revealed there were no wounds. Record review of Resident #42's Physician Orders revealed the following orders from MD A: - Cleanse trach stoma site with SNS and cotton swabs. Dry stoma site with dry 4x4 gauze. Cover with gauze and tape, Every night shift. Ordered on 7/6/23. - Complete the Skin & Wound-Total Body Skin Assessment, Every night shift, every Tue for skin integrity. Ordered on 12/13/23. - Hydrocortisone Gel 1% Apply to affected areas, chest/leg topically as needed for rash/redness. Ordered 3/14/22. - Hydrocortisone Gel 1%, Apply to bilat legs/redness topically BID for redness for 14 days. Ordered on 3/20/24. Record review of Resident #42's February 2024 MAR-TAR revealed he did not receive the Hydrocortisone Gel 1% at all throughout February 2024. Record review of Resident #42's March 2024 MAR-TAR revealed it was documented that the resident received trach stoma site care from 3/14/24 to 3/20/24. The March 2024 MAR-TAR revealed the resident did not receive the Hydrocortisone Gel 1% at all from 3/14/24 to 3/20/24. Record review of Resident #42's progress notes revealed a note from the DON on 3/20/24 at 9:15pm which said, Spoke w/ NP n/o for hydrocortisone cream x 7 days/prn n/o initiated will cont to monitor. In an observation of Resident #42 on 3/19/24 at 1:44pm, he was laying on his back in bed. The resident's trach stoma was uncovered and did not have the ordered gauze on it. In an observation of Resident #42 on 3/20/24 at 10:16am, he was laying on his back in bed. The resident's trach stoma was uncovered and did not have the ordered gauze on it. In an observation of Resident #42 on 3/20/24 at 3:21pm, he was laying on his back in bed. He had deep red excoriations on both shins, from below his knee down to his ankles. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview of Resident #42 on 3/20/24 at 4:21pm, he was laying on his back in bed. The DON observed the excoriations on the resident's shins and said the resident had a cream the nurses were using to treat it. She did not know why his trach stoma was not covered. In an observation of Resident #42 on 3/21/24 at 11:05am, he was up in a Geri chair in the activity room. The resident had his heel protectors on, and his trach stoma was covered and clean. In an interview with LVN C on 3/21/24 at 11:10AM, she said she did not see any redness or problems to Resident #42's legs and did not apply any creams to them. In an interview with the DON on 3/21/24 at 1:30pm, she said the nurses were applying the oily barrier cream instead of the steroid cream because they thought it would be better for the wounds. Record review of the facility's policy and procedure on Professional Standard of Care (revised February 2017) read in part: The community provides services that meet professional standards of quality and are provided by appropriately qualified persons (e.g., licensed, certified). Record review of the facility's policy and procedure on Medication Administration (revised January 2023) read in part: Resident medications are administered in an accurate, safe, timely, and sanitary manner .Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route .Administer medications as ordered by the physician .Initial the electronic administration record after the medication is administered to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy and procedure on Skin and Wound Prevention and Management (revised January 2023) read in part: .At times skin failure may occur; however, the community will ensure that a resident admitting into the community will evaluated and identify the associated risks that may result in with skin breakdown .Thus, a plan of care will be developed and implemented based on the identified needs, associated risks, and current skin conditions. Each resident will receive the care and services necessary to retain or regain optimal skin integrity .Identity early onset skin breakdown so that the IDT may implement appropriate interventions as clinically indicated. Implement interventions designed to stabilize, reduce, or remove underlying risk factors. Ongoing evaluation of the plan of care and modifying or changing interventions as appropriate .The community adopts treatment protocols for the prevention, identification, assessment, and management of skin conditions, wounds, and pressure ulcer injuries .Assessment of a resident's skin condition helps determine prevention strategies. The skin assessment includes an evaluation of skin integrity. The assessment includes documentation of current pressure areas and areas of other interruption of skin integrity other than pressure. Resident's skin should be assessed/evaluated upon admission/re-admission and as clinically indicated. Clinical team members should regularly inspect each resident's skin to identify new skin concerns. A licensed nurse should at least weekly conduct a routine skin assessment/evaluation in order to identify new pressure injuries or other types of skin concerns. The licensed nurse should document the results of weekly skin checks in the resident's medical record .The licensed nurse should document the wound presentation or description of skin issue identified within the electronic health record .The licensed nurse will continue to monitor the status and progress of the wound until resolved. Should the wound deteriorate, the nurse should notify the MD/NP/PA, IDT and resident or representative of the change in condition and document the wound assessment/evaluation findings, notifications, new orders and additional interventions. Thus, the plan of care should be reviewed and updated accordingly. The nurse should continue to monitor the status of the wound and response of the treatment and interventions implemented for effectiveness and collaborate with the IDT and MD/NP/PA for any updates or concerns as identified .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 20 residents (Resident #42) reviewed for quality of care The facility failed to ensure Resident #42's interventions for his bilateral hand rolls (rolls for contractures), posey palm pad (pad in palm for contractures), and getting him up into a Geri chair (chair that helps prevent falls), were implemented. This failure could place residents at risk of a decrease in range of motion, problems with skin integrity, and decreased quality of care. Findings include: Record review of Resident #42's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with an original admitted [DATE]. He had diagnoses of anoxic brain damage (brain damage from lack of oxygen), chronic heart failure (heart does not pump strongly), gastrostomy (tube into stomach for nutrition), dysphagia (unable to swallow), aphasia (unable to talk), hypertension (high blood pressure), GERD, duodenal ulcer (ulcer in the small intestine), and muscle weakness. Record review of Resident #42's Annual MDS assessment dated [DATE], revealed a BIMS was not able to be conducted. The staff assessment for mental status revealed the resident had severely impaired cognition. The resident had impairment on both sides of his upper and lower extremities. According to the MDS, the resident was dependent with all ADLs. The resident was high risk for pressure ulcers/injuries but did not have any. According to the MDS, the resident did not receive any PT/OT or restorative nursing. Record review of Resident #42's care plan dated 2/13/20, revealed a Focus: Resident to use Geri Chair when out of bed- d/t poor trunk control (Initiated: 8/2/21, Created: 8/2/21, Revised: 4/16/22). Goal: Resident to tolerate Geri Chair through next review date (Initiated: 8/2/21, Created: 8/2/21, Revised: 1/17/24). Interventions: Staff to monitor resident for safety while in Geri Chair. Staff to place resident in Geri Chair when out of bed for safety. Focus: I have a self care deficit r/t poor physical functioning (Initiated: 6/29/23, Created: 12/30/21, Revised: 6/29/23). Goal: Resident will maintain or improve ability to participate in care with ADLs through next review date (Initiated: 12/30/21, Created: 12/30/21, Revised: 1/17/24). Interventions: Offloading device: I use pressure relieving boots/devices as indicated. Place hand rolls to hands per order. Turning and repositioning: On rounds and as needed. Focus: Resident has a potential for alteration in skin integrity r/t friction, immobility and contractures (Initiated: 10/18/22, Created: 10/18/22, Revised: 10/18/22). Goal: Resident will maintain skin integrity through next review date (Initiated: 10/18/22, Created: 10/18/22, Revised: 1/17/24). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #42's PT Evaluation from 9/13/23 revealed he had plantar flexion contractures (unable to make foot flat) and knee extension contractures (unable to straighten knee). The evaluation recommended positioning, bed mobility, and sitting tolerance in a Geri chair. PT never received authorization from the resident's insurance to continue and was discharged from PT on 10/13/23. Record review of Resident #42's Physician Orders from MD A revealed the following orders: -Pt to wear bilateral hand rolls when in bed as tolerated or up to 8 hours daily to preserve skin and joint integrity. Ordered on 7/23/21. -The patient out of bed can be in a Geri chair. Ordered on 9/14/21. -Heel protectors or float heels on pillow while in bed, Every shift. Ordered on 7/23/23. -Posey palm pad in place Q shift. Ordered on 7/23/23. Record review of Resident #42's March 2024 MAR-TAR revealed he had received: -Heel protectors/float heels on pillow while in bed, every shift. From 3/1/24-3/21/24. -Posey palm pad in place Q shift, Every shift. From 3/1/24-3/21/24. In an observation of Resident #42 on 3/19/24 at 10:16am, he was laying on his back in bed. The resident did not have any positioning devices to his feet or hands. In an interview with Resident #42's family member on 3/19/24 at 10:20am, she said she would come up to the facility every weekend and the resident would not be bathed, shaved, or taken care of. The family member said she had been sick for the past couple of months and has not been able to come up to the facility. In an observation of Resident #42 on 3/19/24 at 1:44pm, resident was laying on his back in bed. Resident #42's roommate stated the facility never got him out of bed and did not bathe him often. There were no positioning devices on his feet or in his hands. In an observation on 3/20/24 at 3:21pm, Resident #42 was laying flat on his back in bed. There were no positioning devices to his feet and there was only 1 hand roll to his left hand. In an observation and interview of Resident #42 on 3/20/24 at 4:21pm, the DON and LVN D observed that the resident was flat on his back in bed. The resident's feet were edematous and were not in any heel protectors or floated on pillows. The resident also did not have both hand rolls or his posey palm pad in place. The DON was notified that the resident had not been out of bed in a Geri chair like recommended either. Per the DON she was not sure why these things were not in place. She said things can happen if residents were not turned. She also said anyone doing rounds could have seen the positioning devices were not on and could have put them on or turned him. She said she would ensure they would be done. In an observation of Resident #42 on 3/21/24 at 11:05am, he was up in a Geri chair in the activity room and had his heel protectors on, along with his hand rolls and posey palm pad. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN C on 3/21/24 at 11:10am, she said she was putting on Resident #42's boots (heel protectors to prevent pressure injury to the feet), even though there were multiple observations without them on. She did not know why he was not in his Geri chair. In an interview with the DON on 3/21/24 at 1:30pm, she said staff could see the care plans/interventions from their POCs in the EMR, and should be implementing the interventions. She said she made rounds throughout the day to make sure interventions were in place and the nurses did too. She also said the ADON made rounds as well. The DON said Resident #42 had risk factors for developing contractures due to the fact that he had a stroke. She said some of the interventions to address the risks of developing contractures were utilizing hand rolls, the boots, and an air mattress. The DON said she knew Resident #42 had bilateral hand contractures and said all staff were responsible for ensuring the devices were in place. The DON said the boots were off because the nurse had just put ointment on his legs and didn't want to put the boots back on right away. In an interview with Med Aide A on 3/21/24 at 2:15pm, she said she would check on residents every 2hrs or every 1hr if a fall risk. She said she could put the boots on and wedges in place and that these interventions would flag for them under the POC in the EMR, so they can see which resident needed what interventions. In an interview with LVN A on 3/21/24 at 2:45pm, she said she ensured the aides were implementing interventions by rounding on her residents. She said she would physically round and place eyes on her residents to ensure they were clean, showered, turned, etc. She said she would implement the interventions herself if they were not done. Record review of the facility's policy and procedure on Range of Motion (revised January 2023) read in part: The community is responsible for ensuring that residents reach and maintain their highest level of range of motion (ROM) and preventing avoidable decline of range of motion .Each resident without a limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition makes a reduction in range of motion unavoidable.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observations, interviews, and record reviews, the facility failed to ensure residents were offered sufficient fluid intake to maintain proper hydration and health for 1 of 20 residents (Residents #8) reviewed for hydration. The facility failed to ensure Resident #8 received adequate fluids from 3/19/24-3/21/24. This failure could place residents at risk for dehydration, electrolyte imbalance, and infections. Findings include: Record review of Resident #8's undated face sheet, revealed she was a [AGE] year-old female admitted on [DATE] with an original admitted [DATE]. She had diagnoses of polyosteoarthritis (arthritis in multiple joints), muscle wasting and atrophy, peripheral neuropathy (burning/numbness in hands/feet), hypertension (high blood pressure), atherosclerotic heart disease (plaque buildup in the heart), urine retention, atrial fibrillation (heart rate goes up and down), and a pacemaker. Record review of Resident #8's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 15 out of 15 which indicated intact cognition. Resident #8 was independent with eating, required setup or clean-up with oral hygiene, and partial/moderate assistance with toileting and personal hygiene, showers/baths, and upper/lower body dressing. She used a wheelchair to get around the facility. According to the MDS, the resident was always continent of bowel and bladder but had obstructive uropathy (obstruction making it hard to urinate) as a diagnosis. She is at risk for pressure ulcers/injuries but did not have any. She was taking diuretics (medications that make you urinate and can dehydrate you) along with antidepressants which can cause dehydration. Record review of Resident #8's care plan dated 3/1/22, revealed a Focus: I have risk for dehydration or potential fluid deficit r/t diuretic use (Initiated: 1/20/23, Created: 3/25/22, Revised: 1/20/23). Goal: Free of symptoms of dehydration, moist mucus membranes, good skin turgor through review date (Initiated: 1/20/23, Created: 3/25/22, Revised: 1/20/23). Interventions: Monitor/document urine output for symptoms of dehydration: concentrated urine, strong odor. Monitor/document/report to MD PRN s/sx of dehydration: decreased urine output, tenting skin, cracked lips, furrowed tongue (grooves in tongue), confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, weight loss (recent/sudden). Focus: I have a self-care deficit r/t poor physical functioning, weakness & debility, incontinent of bowel & bladder, poor physical endurance (Initiated: 1/20/23, Created: 3/25/22, Revised: 1/20/23). Goal: I will maintain or improve my ability to participate in my care with ADLs through my next review date (Initiated: 1/20/23, Created: 3/25/22, Revised: 1/20/23). Interventions: Eating & drinking: I am able to feed my self and drink without physical assistance. May need to prepare my tray/foods and drinks. Mobility: I use a wheelchair. Toileting/Incontinent care x 1 person assistance. Focus: I am at risk for nutritional deficits and/or dehydration risks r/t dx: heart disease, GERD, chronic medical conditions, associated with weight variations (Initiated: 6/26/23, Created: 3/25/22, Revised: 6/26/23). Goal: I will maintain adequate fluid and nutritional status, without s/s of dehydration (Initiated: 1/20/23, Created: 3/25/22, Revised: 1/20/23). Interventions: Provide meals, snack and fluids within my dietary recommendations. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's Physician Orders revealed the following orders from MD B: -Encourage fluids, every shift. Ordered on 11/8/23. -Docusate Sodium Capsule 100mg, Give 1 capsule by mouth BID for constipation. Ordered on 1/12/23. -Senna Tablet 8.5mg, Give 1 tablet by mouth QD for constipation. Ordered 1/12/23. -Furosemide Tablet 80mg, Give 1 tablet by mouth QD for CHF. Ordered on 8/20/23. -Xiidra Ophthalmic Solution 5%, Instill 1 drop in both eyes BID for dry eyes. Ordered on 10/20/23. -Alrex Ophthalmic Suspension, Instill 2 drops in both eyes BID for dry eyes. Ordered 3/12/24. -Artificial Tears Ophthalmic Solution (Artificial Tears), Instill 1 drop in both eyes BID for dry eyes. Ordered on 3/19/24. Record review of Resident #8's March 2024 MAR-TAR revealed the resident received the following: -Furosemide 80mg from 3/1/24-3/21/24. -Alrex Ophthalmic Suspension from 3/12/24-3/21/24. -Artificial Tears from 3/19/24-3/21/24. -Docusate Sodium 100mg from 3/1/24 to 3/21/24. -Senna 8.6mg from 3/1/24 to 3/21/24. -Xiidra Ophthalmic Solution 5% from 3/1/24 to 3/21/24. In an interview and observation of Resident #8 on 3/19/24 at 1:01pm, she was sitting in a wheelchair at the foot of her bed. She said her water pitcher would not get changed for 2 days at a time. She said it was gross and she only used the water out of it to fix her hair. She said the aides would not come and fill her pitcher and she did not know who her aide was that day. The pitcher was about 1/4 full. In an interview and observation of Resident #8 on 3/21/24 at 10:59am, she was laying in bed on her back. She said she was being lazy, and her throat was kind of scratchy. She said her water pitcher still had not been refilled and it had not been refilled since the evening of 3/19/24 even though she asked a nurse to fill it. The pitcher was about 1/4 filled. She did not know the name of the nurse she asked. In an interview with LVN C on 3/21/24 at 11:10am, she said the resident's water pitchers should be filled at least once a shift. (continued on next page)

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	676476	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights on Valley Ranch	23200 Valley Ranch Parkway Porter, TX 77365

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 3/21/24 at 1:30pm, she said it was her expectation that the resident's water pitchers were filled at least once per shift. She said she could not say what could happen if they were not refilled because it depended on the resident's background and other concerns going on. In an interview with Med Aide A on 3/21/24 at 2:15pm, she said she rounded on residents every 2hrs or every 1hr if they were a fall risk. She said she filled the water pitchers up at the beginning of her shift and at the end of her shift, and at any time during her shift if the resident requested it. In an interview with CNA A on 3/21/24 at 2:22pm, she said she rounded every 30min to 2hrs depending on the resident and gets the resident's whatever they needed, including filling water pitchers. In an interview with CNA B on 3/21/24 at 2:32pm, she said she rounded on residents at least every 2hrs but usually less. She said she filled the water pitchers at least once per shift. In an interview with LVN A on 3/21/24 at 2:45pm, she said she ensured the aides did their jobs by making rounds and looking at the residents to ensure they were clean, turned, showered, etc. She said sometimes she would do the care herself if it needed to be done. In an interview with LVN B on 3/21/24 at 3:43pm, she said she ensured the aides did what they were supposed to by setting alarms for every 2hrs. Also, if she noticed the resident needed some kind of care, she would tell the aide to stop what they were doing and provide the care for the resident at that moment. Record review of the facility's policy and procedure on Certified Nurse Aide Standards of Clinical Practice (revised January 2023) read in part: Certified Nursing Assistants (CNA) should provide services and care for residents under the direction and supervision of the licensed nurse .The CNA follows the standards and procedures in the provision of services and care for residents. The CNA assists the resident in activities of daily living such as feeding, drinking .The CNA makes rounds to check each assigned resident's condition and ensure their needs are met. The CNA answer call lights promptly and assists residents as required. Record review of the facility's policy and procedure on Routine Resident Care (revised January 2023) read in part: Residents should receive the necessary assistance to maintain good grooming and personal/oral hygiene .Licensed nurses and non-licensed direct team members .Resident call lights should be answered timely and resident requests are addressed, if permitted .Bedside tables and essential items, such as a water pitcher, should be kept within reach of the resident .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observations, interviews, and record reviews, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #42) of 1 resident reviewed for gastrostomy tube management. The facility failed to follow the physician orders for Resident #42's enteral water flush (a set amount of water that is delivered into the digestive system via the feeding tube) that was ordered on 3/15/24. This failure could place residents at risk for fluid overload and nutritional deficits. Findings include: Record review of Resident #42's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with an original admitted [DATE]. He had diagnoses of anoxic brain damage (brain damage from lack of oxygen), chronic heart failure (heart does not pump strongly), gastrostomy (tube into stomach for nutrition), dysphagia (unable to swallow), aphasia (unable to talk), hypertension (high blood pressure), GERD, duodenal ulcer (ulcer in the small intestine), and muscle weakness. Record review of Resident #42's Annual MDS assessment dated [DATE], revealed a BIMS was not able to be conducted. The staff assessment for mental status revealed the resident had severely impaired cognition. The resident had impairment on both sides of his upper and lower extremities. According to the MDS, the resident was dependent with all ADLs. The MDS revealed the resident used a feeding tube (a tube into the stomach to receive nutrition) while a resident. He received 51% or more total calories through the feeding tube and received 500ml/day or less of fluid intake through the feeding tube. The resident was high risk for pressure ulcers/injuries but did not have any. Record review of Resident #42's care plan dated 2/13/20, revealed a Focus: The resident is at risk for nutritional deficits r/t being dependent on staff for hydration and nutrition (Initiated: 3/16/20, Created: 2/13/20, Revised: 3/16/20). Goal: Resident will maintain adequate nutritional status through review date (Initiated: 3/16/20, Created: 2/13/20, Revised: 1/17/24). Interventions: Staff to administer feeding and fluids as ordered. Provide enteral (through the intestine) feedings and flushes as recommended by my physician. Focus: The resident requires a feeding tube r/t dysphagia (trouble swallowing) causing a risk for complications (Initiated: 2/13/20, Created: 2/13/20, Revised: 8/14/20). Goal: Resident will not experience any complications associated with my feeding tube (Initiated: 2/27/20, Created: 2/27/20, Revised: 1/17/24). Interventions: Administer tube feeding per doctor's orders. RD to evaluate as indicated. Record review of Resident #42's progress notes revealed a note from the RD on 3/12/24 at 5:46pm, that revealed she recommended to decrease the free water flush from 220ml Q4hr to 160ml Q4hr to better meet the resident's fluid needs. Record review of Resident #42's Physician Orders revealed an order from MD A for the following order: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Enteral Feed Order, every 4hrs flush with 180ml water. Ordered on 3/15/24. Record review of Resident #42's March 2024 MAR-TAR revealed the staff had signed off that they had flushed the PEG tube (tube into stomach for nutrition) Q4hr with 180ml of water on 3/15/24-3/21/24. In an observation on 3/19/24 at 1:44pm, Resident #42 was laying on his back in bed. He had a feeding tube running Osmolite 1.5 (type of tube feeding formula) at 65ml/hr with water flush at 220ml Q4hr. The resident was unable to speak/communicate or move. In an observation on 3/20/24 at 10:16am, Resident #42 was asleep in bed on his back. Osmolite 1.5 (type of tube feeding formula) was running at 65ml/hr with the water flush at 220ml Q4hr. In an observation and interview on 3/20/24 at 4:21pm with the DON and LVN D, Resident #42 was laying on his back in bed with his PEG tube running and the water flush at 220ml Q4hr. The resident's feet were moderately swollen. The DON said she was not sure why the water flush would be wrong and would have to look at the orders and get back. In an interview with the DON on 3/21/24 at 10:20am, she said the reason the water flush was wrong for Resident #42 was because the order was just changed on 3/15/24. She said the nursing staff must have not seen the order. She also said she did not think anything would happen if the resident received too much fluid because G-tubers needed more water anyways. Record review of the facility's policy and procedure regarding Enteral Nutrition (revised January 25, 2022) read in part: .A resident who is fed by nasogastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers .The nurse checks the orders for the enteral feeding, enteral flush frequency orders for pre and post meds and free water orders for enteral nutrition/hydration .Once the tube has been placed and tube placement confirmed, the nurse administers the enteral feeding regimen according to formula, system type, and method of delivery ordered by the physician .The nurse irrigates the feeding tube with the prescribed amount of water per physician to maintain or restore patency of the feeding tube and to provide free water to maintain adequate hydration of the resident. Nursing and dietary routinely monitor the following factors for evaluation of therapeutic efficacy, adverse effects, and clinical changes: weight, hydration-signs/symptoms of dehydration or overload (e.g. edema and cardiopulmonary or change in vital signs) .The resident shall be evaluated for intolerance to the enteral feeding regimen. Intolerance may be manifested by: fluid overload . [NAME]. She also said she did not think anything would happen if the resident received too much fluid because G-tubers needed more water anyways. (continued on next page)

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