STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676491	A. Building B. Wing	11/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Ridge Rehab & Nursing Center	401 Swift Street Refugio, TX 78377

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involve abuse or resulted in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 3 residents (Resident #48) reviewed for abuse/neglect reporting. The facility failed to report an allegation of neglect to the State Agency when Resident #48 was found unresponsive on his bathroom floor, went into cardiac arrest, and died at the facility on [DATE]. This failure could place residents at risk for not having allegations of abuse/neglect reported which could lead to injury or a decrease in physical, mental, and/or psychosocial wellbeing. The findings included: Record review of Resident #48's Admission Record reflected a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #48's diagnoses included idiopathic peripheral autonomic neuropathy (damage to the nerves that control automatic body functions such as heart rate, blood pressure, breathing and digestion but the cause of the damage is unknown), hypoglycemia (low blood sugar), unsteadiness on feet, generalized muscle weakness, unspecified abnormalities of gait and mobility, lack of coordination, other reduced mobility, bilateral primary osteoarthritis of knee (the cartilage lining both knee joints is worn down or damaged causing pain, stiffness, swelling, and decreased range of motion), essential (primary) hypertension (high blood pressure), diabetes mellitus (a disorder that causes blood sugar levels to be high), and nocturia (waking up one or more times during the night to urinate). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #48's quarterly MDS dated [DATE] reflected in section C that Resident #48 had a BIMS score of 10 which indicated that he had moderate cognitive impairment. Section GG0115 (Functional Limitation in Range of Motion) reflected that Resident #48 had impairment to both upper extremities (shoulder, elbow, wrist, and/or hand) and both lower extremities (hip, knee, ankle, and/or foot) and that he normally used a wheelchair. Section GG130 reflected that Resident #48 was independent with sitting to standing and transferring from bed to chair (or wheelchair) and back. Resident #48 required set up or clean up assistance with walking 10 feet, walking 50 feet, and walking 150 feet. Section GG170 reflected that Resident #48 used a motorized wheelchair and was able to wheel 50 feet with two turns and was able to wheel 150 feet in a corridor. Section H0200 reflected that Resident #48 was always continent of bladder and bowel. Record review of Resident #48's Care Plan reflected the following: Focus: (Cancelled) Risk for decline due to diabetes mellitus. Goal: Resident #48 will be free from and s/s of hyperglycemia (high blood sugar), Resident #48 will be free from any s/s of hypoglycemia (low blood sugar), and Resident #48 will have no complications related to diabetes through the review date. Focus: (Cancelled) Risk for falls due to pain and neuropathy (damage to the nerves of the hands and/or feet that caused pain, numbness, and weakness). Actual falls: [DATE], [DATE], [DATE]. Goal: Resident #48 will not sustain serious injury; Resident #48 will be free from injury due to falls through review date. Interventions: Be sure the call light is within reach and encourage resident to use it for assistance when needed. Educate resident/ family about safety reminders and what to do if a fall occurs. Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in scooter. Resident uses a raised toilet seat. Focus: (Cancelled) Resident #48 is a full code. Goal: Request for CPR to be initialed will be followed. Record review of Resident #48's Blood Pressure Summary in PCC reflected that Resident #48's blood pressure was documented as ,d+[DATE] on [DATE] at 7:26am. Record review of Resident #48's Blood Sugar Summary in PCC reflected that Resident #48's blood sugar was checked on [DATE] at 9:25pm and was 123 mg/dL. There was no documentation for Resident #48's blood sugar on [DATE] even though it was documented as being done on the MAR. Record review Resident #48's Progress Notes in PCC reflected the following: LATE ENTRY Type: Nursing Progress Note (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Effective date: [DATE] at 9:00pm Created date: [DATE] at 5:37pm Note text: Charge nurse went in to give [Resident #48] medications. Charge nurse did not see resident in room, and when calling his name, no response. Charge nurse then asked the CNA if [Resident #48] was outside. CNA stated no he should be in his room. I stated that he was not in his room and I had called his name but he did not answer. The CNA walked in to check the bathroom and [Resident #48] was on the floor breathing but not responding to verbal commands. EMS (Emergency Medical Services) was called. While EMS was transferring [Resident #48] from the floor to the stretcher, [Resident #48] then coded (did not have a heartbeat and was not breathing). EMS then performed CPR (Cardiopulmonary Resuscitation) and followed their protocols. When EMS went through all their protocols, they called the ER (emergency room) and the ER doctor then stated to stop CPR. The RN was present and pronounced resident dead at 2035 (8:35pm). RP was here in the facility at the time. MD was called to notify of resident passing. [Funeral Home] picked up resident at 2100 (9:00pm) and RP was here and spoke with [FH person]. No belongings taken at this time, RP stated she would be back to get them. Record review of Resident #48's Standard Assessments in PCC reflected the following: An eTransfer Form Effective [DATE] at 7:57pm, however this form was not filled out. (Resident was not transported) Postmortem Assessment Effective [DATE] at 9:00pm and signed by LVN D on [DATE] that reflected: A.1. Location resident was discovered: bathroom. 2. How was the resident discovered: on floor. B.1. Advanced Directive. The resident was DNR? YES (Resident was a Full Code) C. Assessment. Select all that apply: box a. Unresponsive to verbal, tactile, and painful stimuli was the only box checked. D.1. Has an RN pronounced the resident dead: Yes 2. Name of pronouncing RN: RN E The time of death: 8:35pm Discharge Summary Effective [DATE] at 9:00pm, signed by the ADON on [DATE] that reflected: A.A. Reason for discharge: Resident expired. A.1. Date of discharge: [DATE] 2. Diagnosis at time of discharge: (Resident #48's diagnoses are in the space provided) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Brief history: Resident coded while EMS in facility getting ready to transfer to ER. EMS followed their protocol, performed CPR until all measures were taken. ER doctor called off coded and RN E pronounced resident time of death at 8:35pm. 4. Pertinent physical and laboratory findings: None 5. Course of treatment: None This form has the physician's signature and is dated [DATE]. Record review of Resident #48's EMS report reflected the following information in part: CLINICAL IMPRESSION Primary impression: Diabetic Hypoglycemia Chief complaint: Fall Patient's level of distress: Severe Signs and Symptoms: Hypoglycemia (primary) Injury: Falls- Fall, unspecified- 0 ft - Nursing home [DATE] Mechanism of injury: Blunt Medical/Trauma: Medical Barriers of care: Unconscious Alcohol/ drugs: None reported Initial patient acuity: Emergent ASSESSMENTS [DATE] at 7:51pm Mental status: unresponsive Skin: cold Eyes: left pupil 6mm non-reactive, right pupil 6mm non-reactive NARRATIVE [Medic unit] dispatched to [Facility] for elderly male who fell , is unresponsive but breathing. [Medic unit] responded code 3 (lights and sirens) to scene. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AOSTF (arrived on scene to find) 74 Y/O Male laying on his right side next to the commode in his room. Nursing home staff stated that fall was unwitnessed, also that his BGL read low. Patient's ABC's patent, slow/snoring respirations noted, unresponsive, skin cool and dry, vomit noted near patient's face. No deformities, contusions, abrasions, punctures, burns, tenderness, lacerations, or swelling noted Upon placement on stretcher, patient was not breathing. No pulse detected; immediate CPR performed After fourth round of Epi (a medication used to help restart the heart), on line medical control contacted, [ER doctor] gave instruction to cease resuscitation efforts. SPECIALTY PATIENT-CPR Cardiac arrest: yes, after EMS arrival Cardiac arrest etiology: cardiac (presumed) Estimated Time of Arrest: ,d+[DATE] minutes Time 1st CPR: [DATE] at 8:04pm Initial rhythm: Asystole (flat line) End of event: Expired in the field (not in a hospital) Depart scene: 9:47pm DISPATCHED AS: Fall In an interview on [DATE] at 3:15 PM in the Adm's office with the CN present, the Adm stated that Resident #48 was found unresponsive in the bathroom. The Adm stated it was an unexpected death, but Resident #48 had been refusing a lot of help recently such as refusing labs, refusing medications, and would refuse transfer help some days. The Adm stated that Resident #48 was not on hospice but they had started bringing it up with the family member. The Admin stated, I did not talk to the family member, but we had been discussing bringing it up with her and SOMEONE did discuss it with her. I'm not sure who or when. When asked if Resident #48's death should have been reported the CN stated, the death is reportable only if suspicious. They found him unresponsive, called EMS, he coded, CPR initiated, he was pronounced, then released to [the funeral home]. The business office reports deaths through the TULIP website monthly and they usually have until the 5th of the month. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 3:06pm the DON stated that Resident #48 was a frail man, but he was not on hospice or anything, so his death was not expected. The DON stated, I do not remember who called me that night. What was reported to me was, they found him in the bathroom on the floor, he was breathing but not responding. They called 911. EMS came here and as they were getting him ready to transport, he coded, and I believe EMS started CPR. I don't know anything else about his death. The DON stated that the nurse who called her said they did not find any injury. The DON stated that she did not recall that they mentioned anything else. When asked if the death was investigated by the facility, the DON stated there was not an investigation on this death. The DON stated that the CN looked into it because the Adm reported it to corporate. The DON stated, I don't know why it wasn't reported to state. Now, I feel like I should have called it in. It was an unwitnessed fall, and he was unconscious. If they do follow some type of algorithm, I don't know about it. In an interview on [DATE] at 4:36pm in the Adm's office with the Adm present, when asked about Resident #48's status when he was found in the bathroom, the CN stated that Resident #48 was responsive, just not to verbal. When asked if unresponsive meant the same as not responsive, the CN clarified that Resident #48 was unresponsive, but he was breathing. When asked if Resident #48 being on the floor in his bathroom meant that he had sustained an unwitnessed fall, the CN stated, I'm not sure if he had a fall. I would not assume that he did. I can just go by what I see in the chart and what I see documented. When asked if a resident that was found unresponsive after a fall should have been reported the CN stated, I'm still saying no it did not need to be reported. When asked if she concurred, the Adm stated, I concur . Record review of the Long-Term Care Regulation Provider Letter numbered PL ,d+[DATE] that was provided by the DON reflected in part: Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) Date Issued: [DATE] 1.0 Subject and Purpose This letter provides a guidance for reporting to HHSC. It also clarifies the types of events that are not reportable to HHSC, and updates rule references. To aid providers in understanding the reporting requirements, this letter includes: Attachment 2, a flow chart to assist in decisions about making reports. 2.0 Policy Details and Provider Responsibilities 2.1 Incidents that a NF must report to HHSC: A NF must report to CII the following types of incidents, in accordance with applicable state and federal requirements: Death due to unusual circumstances (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Suspicious injuries of unknown source 2.4 Reportable Incidents and Timeframes This table describes required reporting timeframes for each incident type. It also describes events a NF is not required to report: Type of Incident: Do Report: an incident that results in serious bodily injury and that involves any of the following: Injuries of unknown source When to Report: Immediately, but not later than two hours after the incident occurs or is suspected. Type of Incident: Do Report: an incident that does not result in serious bodily injury but that involves any of the following: A death under unusual circumstances When to Report: Immediately, but no later than 24 hours after the incident occurs or is suspected. Attachment 1: Definitions and Examples of ANE and other Reportable Incidents Injuries of unknown source: Note: an injury should be classified as an injury of unknown source when ALL of the following conditions are met: The source of the injury was not observed by any person; and The source of the injury could not be explained by the resident; and The injury is suspicious because of: The extent of the injury; or Death due to unusual circumstances. Record review of the facility's Abuse/Neglect Policy/ Procedure TG ,d+[DATE].0 Rev: [DATE] reflected in part: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. Reporting 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter ,d+[DATE] dated [DATE]. a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation. F. Investigation Comprehensive investigations will be the responsibility of the administrator and/ or the Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. 1. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC. 2. After receipt of the allegation the Abuse Preventionist and administrator in conjunction with Risk Management will immediately evaluate the resident's situation using the criteria as stated in this policy. Determination will be made for required reporting to HHSC per reporting guidelines found in Provider Letter , d+[DATE]. The written report must be sent to HHSC no later than the 5th working day after the initial report. The facility will use the designated state reporting form. 6. The Abuse Preventionist and/ or administrator will conduct a thorough investigation of the incident(s). A copy of the written report will accompany any personnel action deemed necessary. If personnel action occurs, a copy of all pertinent documents will be placed in the employee's file.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on interviews, and record reviews, the facility failed to ensure a PASRR evaluation was completed on newly admitted residents prior to admission or after admission for 1 (Resident #5) of 5 residents reviewed for PASRR screenings. The facility failed to ensure Resident #5's PASRR Level 1 screening indicated he was positive for mental illness. This failure could place residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require. Findings were: Record review of Resident #5's face sheet indicated an admitted on 08/20/20 with diagnoses including Diabetes Primary 08/10/20, Paranoid Schizophrenia 08/10/20, and vascular dementia 08/10/20. Record review of Resident #5's quarterly MDS dated [DATE] documented a BIMS score of 13 indicating he was cognitively intact. He did not display any behaviors during the assessment, and he was independent for all functional abilities. He was ambulatory without assistive devices. He was continent of bladder and bowel. His active diagnoses included medically complex conditions, diabetes, non-Alzheimer's dementia, and schizophrenia. He was taking antipsychotic and antidepressant medications; gradual dose reductions were deemed clinically contraindicated by the physician. Record review of Resident #5's care plan dated 03/20/21 reflected the resident required use of antipsychotic and mood stabilizing medications r/t dx of paranoid schizophrenia *Risperdal, Depakote Date Initiated: 03/04/2021 Revision on: 09/30/2024. Deer Oaks to evaluate and treat Date Initiated: 05/23/2022. The resident has potential fluid deficit r/t impaired cognition, prescribed medication, and continuous pacing. Date Initiated: 03/04/2021 Revision on: 03/20/2021.The resident required antidepressant medication *Trazodone Date Initiated: 06/15/2021 Revision on: 09/30/2024. The resident has an anticonvulsant ordered r/t: schizophrenia Date Initiated: 09/05/2024 Revision on: 09/05/2024. Record review of Resident #5's physician orders revealed Trazodone Tablet 50 MG Give 1 tablet by mouth at bedtime related to primary insomnia Active 6/14/2024. Risperdal Tablet 2 MG (risperidone) Give 1 tablet by mouth two times a day related to paranoid schizophrenia Active 3/22/2021. Depakote Sprinkles Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 2 capsule by mouth one time a day related to paranoid schizophrenia 2 capsules=250MG. Do not crush. Active 3/2/2021. May go out of facility to attend heritage program as scheduled Active 10/7/2024. Record review of Resident #5's PASRR L1 dated 08/10/20, Section C0100. Mental Illness (MI) Is there evidence or an indicator this is an individual that has a Mental Illness? No. Section C0200. Intellectual Disability (ID) Is there evidence or an indicator this is an individual that has an Intellectual Disability? No. Section C0300. Developmental Disability (DD) Is there evidence or an indicator this is an individual that has a Developmental Disability? No. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the MDS nurse on 11/07/24 at 2:35 PM she said Resident # 5's diabetes was his primary diagnosis and his paranoid schizophrenia was secondary as reflected in his EHR. She said his PASRR dated 08/10/20 was negative. She produced a 1012 dated 11/10/21 and said there was no evaluation. In an interview with the MDS nurse on 11/07/24 at 3:30 PM, she said Resident # 5's 1012 was never sent and his diagnoses were misaligned, that dementia was supposed to be his primary diagnosis. She said she was under the impression that when dementia was a primary diagnosis, it negated any mental illnesses and therefore the PL1 would be negative. However, dementia was not listed as his primary diagnosis and the 1012 should have been sent because the decision was not the facility's to make. She said and Resident # 5 could have missed out on any specialized therapy or equipment services he might have required. In an interview with the MDS nurse on 11/07/24 at 4:30 PM, she said she re-submitted the L1 and sent a 1012 for Resident #5. She said she was responsible for reviewing PASRR when residents were admitted . She said she should have been paying more attention and from now on, she would. She said resident's could be getting services they otherwise would not get without a proper screening. Record review of the facility policy revised 03/06/19 titled PASRR Nursing Facility Specialized Services (NFSS) Policy and Procedure under Policy: It is the policy of Creative Solutions in Healthcare facilities to ensure NFSS forms are submitted timely and accurately. Under Procedure: 1. PL1 is completed. 2. If PL1 is coded as suspicion of MI, ID, or DD, then a PASRR Evaluation (PE) is required.

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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** 44748 Based on observations, interviews, and record review, the facility failed to ensure that the comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, for 1 resident (Resident #43) of 5 residents whose care plans were reviewed for timing and revision. Resident #43's care plan was not revised after his diet was changed from mechanical to nothing by mouth. Resident #43's care plan was not revised after returning from a local hospital with a new g-tube (feeding tube). Resident #43's care plan was not revised after enteral feeding was started. Resident #43's most recent care plan dated 10/15/24 was not revised after an actual fall on 10/31/24. This failure could place residents at risk for inadequate care. The findings included: Record review of Resident #43's face sheet dated 10/12/24 reflected a [AGE] year-old male with an original admitted [DATE], and an initial admitted [DATE]. Diagnoses included Giardiasis 10/12/24 (a common parasitic intestinal infection causing diarrhea and prevalent in areas with poor sanitation and unsafe water), Methicillin Resistant Staphylococcus (a type of bacteria that is resistant to many antibiotics; a staph infection that does not respond well to the antibiotics that usually treat staph infections), Gastrostomy 09/13/24 (a surgically placed tube that provides access to the stomach for feeding. Latin for stomach and new opening), Enterocolitis (inflammation of the small intestine) r/t clostridium difficile 09/12/24 (a highly contagious bacterium and a leading cause of diarrhea worldwide that is associated with antibiotics), gastro-esophageal reflux disease, chronic respiratory failure due to pneumonia 08/22/24 or aspiration pneumonia 04/24/24 (inhalation of food and vomit), malnutrition, unspecified dementia, stroke 04/24/24 with subsequent memory and cognitive deficits, aphasia (a language disorder that can cause a person to lose the ability to speak, understand language, or both. It is caused by damage to specific regions of the brain, usually from a stroke or head trauma), and dysphagia (the muscles used for swallowing do not work properly, making it difficult or impossible to safely swallow food, liquids, or saliva. It is commonly caused by a stroke). Record review of Resident #43's quarterly MDS revealed a BIMS score of 01, indicating severe cognitive impairment. He was total care requiring maximal assistance for all functional abilities. He was incontinent of bladder and bowel. His active diagnosis was medically complex conditions. He was receiving an anticoagulant and antibiotics. Record review of Resident #43's care plan dated 04/25/24 and revised on 11/02/24 revealed revealed no updates regarding his diet change from mechanical to NPO, after returning from a local hospital with a new g-tube, and after enteral feeding was started: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: o Resident has a diet order other than Regular and is at risk for unplanned weight loss or gain. Diet: NPO Date Initiated: 09/06/2024 Revision on: 10/04/2024. Interventions: o Determine food preferences and provide within dietary limitations. Date Initiated: 05/11/2024. o Encourage meal completion and document amount consumed. Date Initiated: 05/11/2024. o Offer sub if resident eats less than 50% or dislikes meal and offer supplement if resident continues to eat less than 50%. Date Initiated: 05/11/2024 Praise resident for eating well. Date Initiated: 05/11/2024. o Red Glass Program Date Initiated: 07/04/2024 o Resident requires frequent cueing at mealtimes Date Initiated: 7/04/2024 o Serve diet and snacks as ordered Date Initiated: 05/11/2024 o The resident has mechanically altered diet Date Initiated: 05/11/2024. Record review of Resident #43's most recent care plan dated 10/15/24 and revised on 10/23/24 revealed no updates regarding a fall on 10/31/24 requiring transfer to a local hospital due to bleeding from a thumb laceration and a skin tear on his finger or care of the laceration and skin tear. There were no updates regarding another transfer to a local hospital and same day return on 11/03/24 for fever, high heart rate, and coughing with increased secretions requiring frequent suctioning. Focus: The resident is risk for falls r/t history of falls Date Initiated: 05/11/2024 Revision on: 05/11/2024 Goals: The resident will be free of falls through the review date. Date Initiated: 05/11/2024 Target date: 10/22/24. Record review of Resident #43's physician orders: Weekly Weights (g-tube) one time a day every Wed. Active 11/6/2024. Weekly Weights (g-tube) one time a day every Wed. Discontinued 11/6/2024 6:00 AM by the ADON. Mucus Relief Oral Tablet (Guaifenesin) Give 1 tablet via G-Tube four times a day for cough / congestion. Active 11/02/24. NPO diet, NPO texture, NPO consistency Diet Active 10/12/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Ridge Rehab & Nursing Center	401 Swift Street Refugio, TX 78377

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #43's progress notes: transferred to a hospital on 10/31/2024 at 1:00 AM related to fall; laceration to left thumb - bleeding due to Eliquis. 11/3/2024 at 11:06 AM Patient exited facility via stretcher accompanied by staff and paramedics by ambulance for hospital evaluation. All appropriate paperwork completed, copied, and given to paramedics. 11/3/2024 at 3:36 PM Resident returned to facility via EMS. Per hospital paperwork, patient presenting with right upper lobe, and bilateral lower lobe ground glass opacities. (Infection and/or scarring possibly caused by pneumonia). Record review of Resident #43's weekly weights report revealed he was weighed on 09/25/24 (127 lbs.), 10/02/24 (128.5 lbs.), 10/12/24 133 lbs.), 10/16/24 (133 lbs.), and 10/30/24 (133.5 lbs.), which was the last documented weight. Observation of Resident #43 on 11/04/24 at 10:00 AM revealed he was non-interviewable and did not respond to questions. He was slowly moving both legs back and forth in bed. His eyes were open and he did not turn his head or move his eyes to the sound of his name. He was thin but not gaunt. In an interview with the DON and the ADON on 11/07/24 at 1:06 PM, the ADON said Resident #43 contracted COVID and pneumonia around the middle of October 2024. The DON said Resident # 43's care plan had not been updated for his hospitalization s which should have included the removal of the red glass program because he went to the hospital on 08/29/24-09/06/24 and came back with a g-tube. The DON said Resident #43 was hospitalized again on 10/05/24-10/12/24 for COVID/aspiration pneumonia and returned with Giardia. The DON said Resident #43 went to the emergency roiagnom on [DATE] and returned, then Resident #43 went to the hospital again from 10/31/24 - 11/01/24 after a fall from his bed with a laceration to his thumb and bruising on his head. The DON said a stroke was ruled out. The DON said Resident #43's responsible party requested he be transferred on 11/03/24 for low grade fever and high heart rate. The ADON said Resident # 43 was on weekly weights because he had a g-tube, and they did not need an order for that because it was in their g-tube program. The ADON said the registered dietician was referred only when necessary. The ADON said the weight watcher program should be in the care plan with the interventions per the Red Glass and Fortified Food Program. The ADON explained the Red Glass program was mostly for resident's that were eating food because the supplements listed were in the program were for PO (by mouth) residents. She said a red glass on a resident's tray was there to alert staff to pay closer attention to those resident's food and fluid intake. The ADON did not answer as to why Resident #43 continued to be on the Red Glass Program since he was receiving enteral feeding. The ADON said weights were done every Wednesday, and Thursday was the deadline. The ADON said the CNA's weigh the residents and she entered the weights. She said Resident #43 did not have a weight done on 11/06/24 as ordered because he was already on weekly weights. The ADON said she had not paid attention to the dates Resident #43 weights had been taken. The ADON was unaware Resident #43 had not been weighed upon his return with a g-tube from the hospital. The DON said Resident #43 should have been weighed upon his return from the hospital. They both said nursing was responsible for updating care plans. They both said the care plans were integral to resident care. They both said they were unaware nursing staff were not updating care plans. The DON said the care plans were supposed to paint the picture of all aspects of the resident in order to measure if interventions were meeting the goals set forth by the interdisciplinary team. Record review of the facility's Red Glass and Fortified Food Program dated 2012 revealed under Procedure: 2. Residents on enteral feedings with unfavorable weight changes will be re-evaluated for protein, calorie, and vitamin/mineral needs with adjustments recommended as needed by the registered dietician. There were no other referrals related to enteral feeding. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated policy titled Comprehensive Care Planning revealed: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following- The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Care planning drives the type of care and services that a resident receives. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set to assess the resident's clinical condition, cognitive and functional status, and use of services. Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered will be recorded in the medical record. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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F 0684 Level of Harm - 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** 49157 Based on interview, and record review, the facility failed to ensure that a resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, for 1 of 3 residents (Resident #48) reviewed for quality of care. 1. The facility staff failed to ensure blood sugar checks were completed per physician's orders. Resident #48's blood sugar level dropped below normal causing him to become unresponsive then subsequently coded while he was in EMS care at the facility. 2. The facility failed to ensure that LVN G documented Resident #48's blood sugar result on the morning of [DATE]. 3. The facility failed to ensure that LVN D documented Resident #48's FSBG (Finger Stick Blood Glucose) result when LVN D checked his blood sugar and it was below normal after Resident #48 was found unresponsive on his bathroom floor. 4. The facility failed to ensure that LVN D or RN E documented administration of Glucagon Emergency Injection Kit 1mg (Glucagon rDNA) to Resident #48 when he was found unresponsive on his bathroom floor and his FSBG result was below normal. 5. The facility failed to ensure that LVN D accurately and timely documented in the progress notes in Resident #48's EHR when Resident #48 was found unresponsive on his bathroom floor, went into cardiac arrest, and died at the facility on [DATE]. 6. The facility failed to ensure that LVN D accurately and timely documented Resident #48's Postmortem Assessment in PCC after Resident #48 died at the facility on [DATE]. 7. The facility failed to ensure that the ADON accurately and timely documented Resident #48's Discharge Summary in PCC after Resident #48 died at the facility. These failures could place the residents at risk of not receiving care and services to maintain their highest practicable physical, mental, and psychosocial well-being. The findings included: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #48's Admission Record reflected a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #48's diagnoses included idiopathic peripheral autonomic neuropathy (damage to the nerves that control automatic body functions such as heart rate, blood pressure, breathing and digestion but the cause of the damage is unknown), hypoglycemia (low blood sugar), unsteadiness on feet, generalized muscle weakness, unspecified abnormalities of gait and mobility, lack of coordination, other reduced mobility, bilateral primary osteoarthritis of knee (the cartilage lining both knee joints is worn down or damaged causing pain, stiffness, swelling, and decreased range of motion), essential (primary) hypertension (high blood pressure), diabetes mellitus (a disorder that causes blood sugar levels to be high), and nocturia (waking up one or more times during the night to urinate). Record review of Resident #48's quarterly MDS dated [DATE] reflected in section C that Resident #48 had a BIMS score of 10 which indicated that he had moderate cognitive impairment. Section GG0115 (Functional Limitation in Range of Motion) reflected that Resident #48 had impairment to both upper extremities (shoulder, elbow, wrist, and/or hand) and both lower extremities (hip, knee, ankle and/or foot) and that he normally used a wheelchair. Section GG130 reflected that Resident #48 was independent with sitting to standing and transferring from bed to chair (or wheelchair) and back. Resident #48 required set up or clean up assistance with walking 10 feet, walking 50 feet, and walking 150 feet. Section GG170 reflected that Resident #48 used a motorized wheelchair and was able to wheel 50 feet with two turns and was able to wheel 150 feet in a corridor. Section H0200 reflected that Resident #48 was always continent of bladder and bowel. The assessment reflected Resident #48 was independent with eating. Record review of Resident #48's Care Plan reflected the following: Focus: (Cancelled) Risk for decline due to diabetes mellitus. Goal: Resident #48 will be free from and s/s of hyperglycemia (high blood sugar), Resident #48 will be free from any s/s of hypoglycemia (low blood sugar), and Resident #48 will have no complications related to diabetes through the review date. Focus: (Cancelled) Risk for falls due to pain and neuropathy (damage to the nerves of the hands and/or feet that caused pain, numbness, and weakness). Actual falls: [DATE], [DATE], [DATE]. Goal: Resident #48 will not sustain serious injury; Resident #48 will be free from injury due to falls through review date. Interventions: Be sure the call light is within reach and encourage resident to use it for assistance when needed. Educate resident/ family about safety reminders and what to do if a fall occurs. Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in scooter. Resident uses a raised toilet seat. Focus: (Cancelled) Resident #48 is a full code. Goal: Request for CPR to be initialed will be followed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #48's Order Summary Report with active orders as of [DATE] reflected the following orders: 1. Accucheck for s/s of hypoglycemia or hyperglycemia as needed r/t diabetes mellitus. Order date [DATE]. 2. Blood sugar checks two times a day related to hypoglycemia. Order date [DATE]. 3. Full Code. Order date [DATE] 4. Glucagon Emergency Injection Kit 1mg (Glucagon rDNA). Inject 1mg subcutaneously as needed for hypoglycemia. Order date: [DATE]. 5. Glucose Oral Gel 40% (Dextrose-Diabetic use). Give 1 vial by mouth as needed for hypoglycemia. Administer for blood glucose <60. 6. Amlodipine Besylate Tablet 10mg. Give 1 tablet by mouth one time a day r/t HTN. Hold if SBP (Systolic blood pressure) <110 or DPB (diastolic blood pressure) <60. Record review of Resident #48's MAR (Medication Administration Record) in PCC dated [DATE] reflected the following: 1. Amlodipine Besylate Tablet 10mg was not given due to vital signs being outside of parameters. (Resident #48's blood pressure was documented as ,d+[DATE]). 2. Glucagon Emergency Injection Kit 1mg did not have any documented administrations. 3. Glucose Oral Gel 40% did not have any documented administrations. 4. Blood sugar checks 2 times a day was blank where there should be a checkmark if Resident #48's blood sugar was checked on [DATE] at or near 6:30am 5. Blood sugar checks 2 times a day had a checkmark on [DATE] at 6:30am which indicated that Resident #48's blood sugar was checked at or near that time. 6. Accucheck as needed for s/s of hypoglycemia or hyperglycemia did not have any documented checks (all of the boxes were blank) for the month of [DATE]. Record review of Resident #48's Blood Sugar Summary in PCC reflected that Resident #48's blood sugar was 111 mg/dL on [DATE] at 9:00 am. There was no documentation for Resident #48's blood sugar on [DATE] even though it was documented as being done on the MAR on [DATE] at 6:30am. Record review Resident #48's Progress Notes in PCC reflected the following: LATE ENTRY Type: Nursing Progress Note (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Effective date: [DATE] at 9:00pm Created date: [DATE] at 5:37pm Note text: Charge nurse went in to give [Resident #48] medications. Charge nurse did not see resident in room, and when calling his name, no response. Charge nurse then asked the CNA if [Resident #48] was outside. CNA stated no he should be in his room. I stated that he was not in his room and I had called his name but he did not answer. The CNA walked in to check the bathroom and [Resident #48] was on the floor breathing but not responding to verbal commands. EMS (Emergency Medical Services) was called. While EMS was transferring [Resident #48] from the floor to the stretcher, [Resident #48] then coded (did not have a heartbeat and was not breathing). EMS then performed CPR (Cardiopulmonary Resuscitation) and followed their protocols. When EMS went through all their protocols, they called the ER (emergency room) and the ER doctor then stated to stop CPR. The RN was present and pronounced resident dead at 2035 (8:35pm). RP was here in the facility at the time. MD was called to notify of resident passing. [Funeral Home] picked up resident at 2100 (9:00pm) and RP was here and spoke with [FH person]. No belongings taken at this time, RP stated she would be back to get them. Record review of Resident #48's Standard Assessments in PCC reflected the following: Postmortem Assessment Effective [DATE] at 9:00pm and signed by LVN D on [DATE] that reflected: A.1. Location resident was discovered: bathroom. 2. How was the resident discovered: on floor. B.1. Advanced Directive. The resident was DNR? YES (That was incorrect, Resident #48 was a Full Code) C. Assessment. Select all that apply: box a. Unresponsive to verbal, tactile, and painful stimuli was the only box checked. The other boxes that were not checked were: box b. No respirations auscultated (heard) with stethoscope at bilateral (both left and right) lung fields, box c. No apical pulse auscultated (no heartbeat heard) with stethoscope and no carotid pulse is palpable, box d. pupils are fixed and dilated, box e. body temperature indicates hypothermia; skin is cold relative to the resident's baseline skin temperature, box f. generalized cyanosis (bluish discoloration of the skin or mucous membranes). D.1. Has an RN pronounced the resident dead: Yes 2. Name of pronouncing RN: RN E 3. Time of death: 8:35pm G.3. Date/time (physician) notified: [DATE] at 8:35pm Date/time (Responsible party) notified: [DATE] at 8:35pm Postmortem Assessment Effective [DATE] at 9:00pm and signed by LVN D on [DATE] that reflected: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Struck out by: LVN D Struck out reason: wrong date/time Struck out date: [DATE] at 5:40pm B.1. The resident was DNR? No (That was correct, Resident #48 was a Full Code) C. Assessment (The information was the same as the above assessment) D.3. Time of death: 8:35am (incorrect) G.3. Date/time (physician) notified: [DATE] at 8:40am (incorrect) Date/time (Responsible party) notified: [DATE] at 8:35pm (correct) Discharge Summary Effective [DATE] at 9:00pm and signed by the ADON on [DATE] that reflected: A.A. Reason for discharge: Resident expired. A.1. Date of discharge: [DATE] 2. Diagnosis at time of discharge: (Resident #48's diagnoses are in the space provided) 3. Brief history: Resident coded while EMS in facility getting ready to transfer to ER. EMS followed their protocol, performed CPR until all measures were taken. ER doctor called off coded and RN E pronounced resident time of death at 8:35pm. 4. Pertinent physical and laboratory findings: None (none of the information about the resident being found on the floor in his bathroom unresponsive nor his fingerstick that was done by the facility prior to EMS arrival and indicated that his blood sugar was low were documented here) 5. Course of treatment: None (The Glucagon administration that was done by the facility prior to EMS arrival was not documented here) This form has the physician's signature and is dated [DATE]. Discharge Summary effective [DATE] at 9:00pm and signed by LVN D on [DATE] that reflected: Struck out by: LVN D Struck out reason: incorrect documentation. Struck out date: [DATE] at 5:38pm A.A. Reason for discharge: Resident expired at 8:35am (incorrect time) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A.3. Brief history: (The same information as the above discharge summary except that it states RN E pronounced resident time of death at 8:35am) A.4. Pertinent physical and laboratory findings: N/A (none of the information about the resident being found on the floor in his bathroom unresponsive nor his fingerstick that was done by the facility prior to EMS arrival and indicated that his blood sugar was low were documented here) A.5. Course of treatment: None (The Glucagon administration that was done by the facility prior to EMS arrival was not documented here) Record review of Resident #48's EMS report dated [DATE] reflected the following information: CLINICAL IMPRESSION Primary impression: Diabetic Hypoglycemia Chief complaint: Fall Patient's level of distress: Severe Signs and Symptoms: Hypoglycemia (primary) Injury: Falls- Fall, unspecified- 0 ft - Nursing home [DATE] Mechanism of injury: Blunt Medical/Trauma: Medical Barriers of care: Unconscious Alcohol/ drugs: None reported Initial patient acuity: Emergent VITAL SIGNS 7:52pm AVPU: U (Unresponsive) BP: ,d+[DATE] P: 84 SpO2: 69% BG: LOW GCS: 6 ASSESSMENTS [DATE] at 7:51pm Mental status: unresponsive Skin: cold Eyes: left pupil 6mm non-reactive, right pupil 6mm non-reactive NARRATIVE (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[Medic unit] dispatched to [Facility] for elderly male who fell , is unresponsive but breathing. [Medic unit] responded code 3 (lights and sirens) to scene. AOSTF (arrived on scene to find) 74 Y/O Male laying on his right side next to the commode in his room. Nursing home staff stated that fall was unwitnessed, also that his BGL read low. Nursing home staff had administered 1mg of Glucagon prior to arrival. Patient's ABC's patent, slow/snoring respirations noted, unresponsive, skin cool and dry, vomit noted near patient's face. No deformities, contusions, abrasions, punctures, burns, tenderness, lacerations, or swelling noted. Patient placed on monitor, blood pressure cuff and pulse ox. BGL checked by EMS, read low. IV established to (left antecubital with a 20 gauge intravenous catheter). Patient administered D10 drip (10% dextrose (sugar) solution in water- used to help increase a person's blood sugar) wide open rate. Patient moved from original position to supine. Patient placed on soft c-collar (device used to stabilize the neck), slid on to vacuum mattress. Patient secured and carried to stretcher. Upon placement on stretcher, patient was not breathing. No pulse detected; immediate CPR performed. Patient moved from stretcher to floor. Patient placed on EKG pads (electrocardiogram pads), asystole noted via manual interpretation. Epi 1:10,000 (Epinephrine- a medication used to help restart the heart) administered every 4 minutes as per protocol. I-gel (a tube that is put into the airway to assist with giving oxygen) placed in patient airway, size 4 with supplemental high flow oxygen, along with in-line ETCO2 (end tidal carbon dioxide- used in conjunction with oxygen when doing CPR), LR (lactated ringers- a solution used to help rehydrate a person) administered IV (intravenously). PEA (pulseless electrical activity- the heart is giving off electrical signals but is not beating) noted during rhythm checks, CPR continued. After fourth round of Epi, online medical control contacted, [ER doctor] gave instruction to cease resuscitation efforts. Family on scene. Dispatch contacted, informed of patient status. Family funeral home contacted by dispatch. Patient remained on scene with family and nursing home staff, awaiting arrival of funeral home staff. EOR (End of Report). [paramedic's name]. Added: Once CPR was initiated, patient was ventilated manually with BVM (bag valve mask) and supplemental oxygen. Patient respirations managed at a rate of 1 breath every 6 seconds. SPECIALTY PATIENT-CPR Cardiac arrest: yes, after EMS arrival Cardiac arrest etiology: cardiac (presumed) Estimated Time of Arrest: ,d+[DATE] minutes Time 1st CPR: [DATE] at 8:04pm Initial rhythm: Asystole (flat line) End of event: Expired in the field (not in a hospital) Date/Time expired: [DATE] at 8:25pm TIMES Call received: 7:42pm Dispatched: 7:43pm (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	En Route: 7:45pm On scene: 7:47pm At patient: 7:49pm Depart scene: 9:47pm DISPATCHED AS: Fall In an interview on [DATE] at 3:15 pm in the Adm's office with the CN present, the Adm stated that Resident #48 was found unresponsive in the bathroom. The Adm stated it was an unexpected death, but Resident #48 had been refusing a lot of help recently such as refusing labs, refusing medications, and would refuse transfer help some days. The Adm stated that Resident #48 was not on hospice but they had started bringing it up with the family member. The Admin stated, I did not talk to the family member, but we had been discussing bringing it up with her and SOMEONE did discuss it with her. I'm not sure who or when. When asked if Resident #48's death should have been reported the CN stated, the death is reportable only if suspicious. They found him unresponsive, called EMS, he coded, CPR initiated, he was pronounced, then released to [the funeral home]. The business office reports deaths through the TULIP website monthly and they usually have until the 5th of the month. In an interview on [DATE] at 3:06pm the DON stated that Resident #48 was a frail man, but he was not on hospice or anything, so his death was not expected. The DON stated, I do not remember who called me that night. What was reported to me was, they found him in the bathroom on the floor, he was breathing but not responding. They called 911. EMS came here and as they were getting him ready to transport, he coded, and I believe EMS started CPR. I don't know anything else about his death. The DON stated that Resident #48 needed assistance to get up to his wheelchair. The DON stated that the nurse who called her said they did not find any injury. The DON stated that she did not recall that they mentioned anything else. When asked about the documentation, the DON stated, the cardinal rule: if you don't document- it didn't happen. When asked what her expectation was the DON stated she would like to see more progress notes done with better detail. The DON stated Resident #48's death should have been documented, as soon as possible but definitely before the end of the shift. The DON stated she would need to ask the ADON about the documentation because she thought the ADON had to call LVN D in to do the postmortem assessment because LVN D did not know how to do it. The DON stated that LVN D was the nurse in that hall that night. RN E was working that night but was not in that hall, but it had to be an RN to pronounce. The DON stated that they did check his blood sugar but did not tell her what it was. The DON stated they also did a full set of vital signs. The DON stated, I would have expected them to document that they checked his sugar or gave him Glucagon prior to EMS arrival. The DON stated she was going to have to do a lot of education and reeducation with the nurses on documentation. The DON stated it was important to document things immediately or as soon as possible because by not documenting Resident #48's morning blood sugar or that it was checked, and glucagon given that evening could call into question what actually happened that day. When asked if the death was investigated by the facility, the DON stated there was not an investigation on this death. The DON stated that the CN looked into it because the Adm reported it to corporate. (continued on next page)

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	676491	A. Building B. Wing	11/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Ridge Rehab & Nursing Center	401 Swift Street Refugio, TX 78377

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 4:36pm in the Adm's office with the Adm present, when asked about Resident #48's status when he was found in the bathroom, the CN stated that Resident #48 was responsive, just not to verbal. When asked if unresponsive meant the same as not responsive, the CN clarified that Resident #48 was unresponsive, but he was breathing. When asked if Resident #48 being on the floor in his bathroom meant that he had sustained an unwitnessed fall, the CN stated, I'm not sure if he had a fall. I would not assume that he did. I can just go by what I see in the chart and what I see documented. In an interview on [DATE] at 4:54pm, CNA F stated yes, she remembered Resident #48 and she was working the night he passed away. CNA F stated dinner was usually right at 6:00pm when the night shift arrived and at about 6:,d+[DATE]:40pm they started getting trays out of the rooms. CNA F stated Resident #48 usually ate in his room and that evening his tray was in the room, but she did not check the tray to see if he had eaten dinner. CNA F stated that Resident #48 had gotten to where he would not eat much, and they would give him a snack and/ or juice around 10:00pm because the nurse would say Resident #48's blood sugar was low. CNA F stated that CNAs did not check blood sugars. CNA F stated Resident #48's rolling walker was right before you got to the bathroom in his room. CNA F stated that she found Resident #48 in the bathroom and stepped out of the room to get LVN D, who went in right away. CNA F stated Resident #48 was on his right side with his head was toward the corner of the bathroom. (Bathroom is roughly 6ft wide by 9ft long.) CNA F stated Resident #48's pants were partway down with urine and feces (diarrhea) on the floor and a moderate amt of brown vomit by his face. CNA F stated there was no blood that she noticed. CNA F stated that Resident #48 had his tennis shoes on. CNA F stated that LVN D checked Resident #48's vital signs while he was on his side on the floor, but she did not remember if LVN D checked Resident #48's blood sugar. CNA F stated that she did not recall that LVN D gave Resident #48 a shot or anything. CNA F stated that LVN D called EMS. CNA F stated that once EMS got there, she stepped out of the bathroom and into Resident #48's room. CNA F stated that EMS put Resident #48 onto the vacuum mat, suctioned the air out, then moved him to the EMS stretcher in the room by the bed. CNA F stated that she reached down to get the foot stretcher belt and when she looked up they noticed Resident #48 was not breathing so EMS took Resident #48 off the stretcher and put him on the floor. CNA F stated she walked out of the room then because there were ,d+[DATE] EMS people in the room. In an interview on [DATE] at 5:20pm, LVN B stated that their glucometer range is 40 to 219mg/dL and it gets QC'd (quality control checked) every day. LVN B stated she did not work on Monday [DATE] but the last time she saw Resident #48 on Sunday [DATE], he was ok and the same as always. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 5:27pm LVN D stated she did remember Resident #48. LVN D stated, We came on shift at 6:00pm. I was going down the hall passing meds. I went to Resident #48's room, knocked on the door, opened it, called out his name and he did not answer. LVN D stated the door to Resident #48's bathroom was open but she did not think that Resident #48 was in there because the bathroom door was open and he always answered if she called his name. LVN D stated she turned and went into the room across from Resident #48 and got ready to give that resident her pills. LVN D stated CNA F came down the hall and she asked CNA F if she knew where Resident #48 was. LVN D stated that CNA F replied that Resident #48 should be in his room. LVN D stated when she told CNA F that she had checked his room and called his name and he was not in there, CNA F went in and checked and found Resident #48 in the bathroom. LVN D stated that when CNA F told her that Resident #48 was on the floor of the bathroom, she stopped what she was doing and went in there. LVN D stated that Resident #48 was laying on his left side with his face toward the door and it looked like he had thrown up a small amount of brown (not coffee ground or bloody) vomit. LVN D stated she did not remember any urine or feces, just the vomit. LVN D stated they checked Resident #48, and he was still breathing, had a pulse, and his eyes were open. LVN D stated she was calling his name, but he was not responding. LVN D stated Resident #48's pants were halfway on, and he had shoes and socks on. LVN D stated she did check all of Resident #48's vital signs but does not recall what they were. LVN D stated she then called EMS and the doctor to let him know that she was going to send Resident #48 out because it looked like he had fallen, and she was concerned that he may have hurt himself based on how they found him. LVN D stated she checked Resident #48's blood sugar and it was low, but she did not remember what the number was. LVN D stated, I believe I did document it, but I do not remember for sure. LVN D stated Resident #48 had an order for Glucagon, so RN E gave it to him when she (LVN D) went to open the door for EMS. LVN D stated that EMS went to his room and did an assessment and CNA F helped to get Resident #48 dressed. LVN D stated, From that point I remember making a phone call to the family member to let her know we were sending him out and when I went back into the room, they told me that when they were transferring Resident #48 to the stretcher, he had coded. LVN D stated that EMS ran the code and that she did not recall them ever getting a pulse back. LVN D stated that Resident #48 was a very independent person and did most things for himself. LVN D stated Resident #48 had a cane that he used to go from his bed to the toilet, but she did not remember if the cane was in the bathroom. LVN D stated she did not know if Resident #48 ate dinner that evening because she had just gotten on shift. When asked to recap what had happened, LVN D stated, This all started around 7:30ish pm. The CNA (CNA F) was coming down the hall picking up hall trays. I asked her if he (Resident #48) was out front because he didn't answer and she said no, he should be in his room. She probably hadn't picked up his tray yet because she was making her way down the hall picking up trays. After I asked about where he was, she went into the room and found him in the bathroom- the bathroom door was open. Originally, the room door was closed because he always kept it closed. When I stepped in his room, the curtain was back. I didn't think to look for his scooter because he didn't answer me, so I assumed he was up front when he didn't answer. I could see the bed, so I knew he wasn't in the bed. I didn't check the bathroom because the bathroom door was open, and he didn't respond back to me. I don't know if he would normally close the bathroom door because I was not very familiar with him. We didn't move anything out of the bathroom, so I know his scooter wasn't in there. LVN D stated she thought she had documented the blood sugar somewhere, maybe on the transfer papers when she was going to send him out. LVN D stated she was going to check in Resident #48's EHR to see if the blood sugar result was documented anywhere, and at 6:13pm, LVN D stated that she was not able to find the documentation of the blood sugar or the glucagon administration in Resident #48's EHR. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on [DATE] at 6:18pm RN E stated she did remember Resident #48 and that she was working the night of his code. RN E stated she was called into Resident #48's room because he was found in the bathroom unresponsive. RN E stated, The first thing that came to my mind was to check his sugar. RN E stated that LVN D told her that Resident #48's sugar was low, so she gave him Glucagon subcutaneously (into the fatty tissue) in his abdomen and as soon as she gave him the injection, EMS was in the room. RN E stated Resident #48 was laying in the corner between the toilet and the wall, he had his head kind of tucked in, so he was more facing the toilet and the back wall by the toilet. RN E stated she did not even know that Resident #48 had coded, but someone told her so she was in the hallway for a little while. RN E stated she was in the room when EMS was using the [NAME] device (a device that does chest compressions automatically so that EMS personnel are able to do other things) on him. RN E stated that EMS called medical control and the ER (emergency room) doctor said to stop CPR. RN E stated she did not remember if she documented the Glucagon or not. RN E stated normally she would document it on the MAR, but everything happened so fast she did not remember if it was documented. RN E stated it was important to document medications that were given to show proof that it was given. RN E stated if medications that were given were not documented, the provider would not know what medications were given, especially if they were PRN (as needed) medications. RN E stated that Resident #48 normally did not go into the bathroom with his scooter, he would ambulate to the bathroom with his 3 wheel walker. RN E stated Resident #48 had fallen a couple of months prior because he would walk really fast with the 3 wheeled walker and wore flip flops. In a telephone interview on [DATE] at 6:35pm LVN G stated she remembered Resident #48 and she was working day shift on [DATE]. LVN G stated she did not remember what his blood pressure was that morning and could not recall if it was lower than normal. LVN G that she did check Resident #48's blood sugar that morning, but I could not recall what it was. LVN G stated normally the result would be documented in the chart in the MAR, but that it had changed so that it was just a check mark for yes it had been checked. LVN G stated she usually kept a log of who she checked sugars on and what they were, but her bag was in her car and her car was in the shop. LVN G stated if Resident #48's sugar had been low she would have gotten him something and called the doctor. LVN G stated Resident #48 was up eating breakfast that morning, he was up in his chair that day, and that he was acting normal and there was nothing out of the ordinary going on for him. LVN G stated she did not know if Resident #48 ate lunch because he ate in his room, and she was in the dining room at lunchtime. LVN G stated it was important to make sure that things were documented so that everyone knew what had or had not been done. LVN G stated, If it wasn't documented, it wasn't done is what we were taught in school. I feel bad that I didn't document it, but if it had been low, I would have done something about it and called the doctor. LVN G stated it was important to document the blood sugar results so that the physician was able to see how they were trending and be able to treat the resident accordingly. LVN G stated usually if Resident #48 felt like his sugar was getting low he would ask her to check his sugar and/or ask for an orange juice. In an interview on [DATE] at 11:53am, the DON stated they had started a 100% check on all of the diabetic residents and residents that had blood sugar checks to make sure that there was a place to document the blood sugar results on the MAR. The DON stated that the issue with Resident #48's blood sugar results not having a space on the MAR was because when the physician changed the order to check it to two times a day, he did not check off the box on the order that required it to be documented in the MAR. The DON stated that they were going to make sure that all of the orders for blood sugar checks had that box checked off. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of the Long-Term Care Regulation Provider Letter numbered PL ,d+[DATE] that was provided by the DON reflected in part: Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) Date Issued: [DATE] 1.0 Subject and Purpose This letter provides a guidance for reporting to HHSC and . It also clarifies the types of events that are not reportable to HHSC, and updates rule references. To aid providers in understanding the reporting requirements, this letter includes: Attachment 1, describing reporting requirements and providing examples to help determine what constitutes a reportable incident. Attachment 2, a flow chart to assist in decisions about making reports. 2.0 Policy Details and Provider Responsibilities 2.1 Incidents that a NF must report to HHSC: A NF must report to CII the following types of incidents, in accordance with applicable state and federal requirements: Death due to unusual circumstances Suspicious injuries of unknown source 2.3 Events that a NF Does Not Need to Report to CII A NF is not required to report to CII: Injury that is not suspicious or of unknown source. Deaths that are not unusual circumstances. 2.4 Reportable Incidents and Timeframes This table describes required reporting timeframes for each incident type. Type of Incident: Do Report: an incident that re [TRUNCATED]

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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. 46038 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for one wound care cart of one reviewed for storage, in that: The facility failed to ensure the wound care cart was locked when left unattended. This deficient practice could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed mediations. The findings included: During an observation on 11/05/24 at 03:41 PM and at 03:46 PM the wound care cart was found unlocked and unattended. This surveyor was able to open all drawers revealing multiple wound care supplies and wound care medications. During an interview on 11/05/24 at 04:05 PM LVN B stated the wound care cart should be locked at all times because anyone could get into the cart. LVN B stated it was important to lock the wound care cart due to anyone would have unauthorized access to supplies and tamper with them or ingest something that could lead to a reaction. LVN B stated she could not recall the last in-service on locking carts. In an interview on 11/06/24 at 08:44 AM the DON stated the wound care cart should not have been left unlocked. The DON stated the wound care cart should be locked at all times for resident, staff, and visitor safety as anyone could get into the wound care cart and grab prescription creams and ointments that are prescribed for specific residents. The DON stated the last in-service on keeping carts locked was about a week ago but would conduct another in-service immediately. on 11/7/24 at 2:03 PM the facility ADM stated there was no specific policy on keeping medication/wound care carts locked when not in use.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented, in accordance with accepted professional standards and practices for 1 (Resident #48) of 3 residents reviewed for clinical records. The facility failed to ensure that LVN G documented Resident #48's blood sugar result on the morning of [DATE]. The facility failed to ensure that LVN D documented Resident #48's blood sugar result on the evening of [DATE] when he was found unresponsive on his bathroom floor. The facility failed to ensure that RN E documented the administration of Glucagon to Resident #48 on the evening of [DATE] when he was found unresponsive on his bathroom floor and his blood sugar was low. The facility failed to ensure that LVN D timely and accurately documented the incident on [DATE] when Resident #48 was found unresponsive on his bathroom floor and passed away at the facility while in EMS care. The facility failed to ensure that LVN D timely and accurately documented the Postmortem Assessment for Resident #48 on [DATE] after he passed away at the facility. The facility failed to ensure that the ADON and/or LVN D timely and accurately documented the Discharge Summary for Resident #48 on [DATE] after he passed away at the facility. The facility failed to ensure that Resident #48 being found unresponsive on his bathroom floor and subsequent death while in EMS care was documented as a fall with major injury. These deficient practices could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. The findings included: Record review of Resident #48's Admission Record reflected a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #48's diagnoses included idiopathic peripheral autonomic neuropathy (damage to the nerves that control automatic body functions such as heart rate, blood pressure, breathing and digestion but the cause of the damage is unknown), diabetes mellitus (a disorder that causes blood sugar levels to be high), hypoglycemia (low blood sugar), unsteadiness on feet, generalized muscle weakness, unspecified abnormalities of gait and mobility, lack of coordination, other reduced mobility, bilateral primary osteoarthritis of knee (the cartilage lining both knee joints is worn down or damaged causing pain, stiffness, swelling, and decreased range of motion), essential (primary) hypertension (high blood pressure), and nocturia (waking up one or more times during the night to urinate). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #48's quarterly MDS dated [DATE] reflected in section C that Resident #48 had a BIMS score of 10 which indicated that he had moderate cognitive impairment. Section GG0115 (Functional Limitation in Range of Motion) reflected that Resident #48 had impairment to both upper extremities (shoulder, elbow, wrist, and/or hand) and both lower extremities (hip, knee, ankle and/or foot) and that he normally used a wheelchair. Section GG130 reflected that Resident #48 was independent with sitting to standing and transferring from bed to chair (or wheelchair) and back. Resident #48 required set up or clean up assistance with walking 10 feet, walking 50 feet, and walking 150 feet. Section GG170 reflected that Resident #48 used a motorized wheelchair and was able to wheel 50 feet with two turns and was able to wheel 150 feet in a corridor. Section H0200 reflected that Resident #48 was always continent of bladder and bowel. Record review of Resident #48's Care Plan reflected the following: Focus: (Cancelled) Risk for decline due to diabetes mellitus. Goal: Resident #48 will be free from and s/s of hyperglycemia (high blood sugar), Resident #48 will be free from any s/s of hypoglycemia (low blood sugar), and Resident #48 will have no complications related to diabetes through the review date. Focus: (Cancelled) Risk for falls due to pain and neuropathy (damage to the nerves of the hands and/or feet that caused pain, numbness, and weakness).Actual falls: [DATE], [DATE], [DATE]. Goal: Resident #48 will not sustain serious injury, Resident #48 will be free from injury due to falls through review date. Interventions: Be sure the call light is within reach and encourage resident to use it for assistance when needed. Educate resident/ family about safety reminders and what to do if a fall occurs. Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in scooter. Resident uses a raised toilet seat. Focus: (Cancelled) Resident #48 is a full code. Goal: Request for CPR to be initialed will be followed. Record review of Resident #48's Order Summary Report with active orders as of [DATE] reflected the following orders: 1. Accucheck for s/s of hypoglycemia or hyperglycemia as needed r/t diabetes mellitus. Order date [DATE]. 2. Blood sugar checks two times a day related to hypoglycemia. Order date [DATE]. 3. Full Code. Order date [DATE] 4. Glucagon Emergency Injection Kit 1mg (Glucagon rDNA). Inject 1mg subcutaneously as needed for hypoglycemia. Order date: [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Glucose Oral Gel 40% (Dextrose-Diabetic use). Give 1 vial by mouth as needed for hypoglycemia. Administer for blood glucose <60. 6. Amlodipine Besylate Tablet 10mg. Give 1 tablet by mouth one time a day r/t HTN. Hold if SBP (Systolic blood pressure) <110 or DPB (diastolic blood pressure) <60. Record review of Resident #48's MAR (Medication Administration Record) in PCC dated [DATE] reflected the following: 1. Glucagon Emergency Injection Kit 1mg does not have any documented administrations. 2. Glucose Oral Gel 40% did not have any documented administrations. 3. Blood sugar checks 2 times a day was blank where there should be a checkmark if Resident #48's blood sugar was checked on [DATE] at or near 6:30am. 4. Blood sugar checks 2 times a day had a checkmark on [DATE] at 6:30am which indicated that Resident #48's blood sugar was checked at or near that time. 5. Accucheck as needed for s/s of hypoglycemia or hyperglycemia did not have any documented checks (all of the boxes were blank) for the month of [DATE]. Record review of Resident #48's Blood Sugar Summary in PCC reflected that there was no documentation for Resident #48's blood sugar on [DATE]. Record review of Resident #48's Progress Notes in PCC dated [DATE] to [DATE] reflected the following entry: Type: Nursing Progress Note Effective Date: [DATE] 9:00pm Created By: LVN D Created Date: [DATE] at 5:37pm Note text: Charge nurse went in to give [Resident #48] medications. Charge nurse did not see resident in room, and when calling his name, no response. Charge nurse then asked the CNA if [Resident #48] was outside. CNA stated no he should be in his room. I stated that he was not in his room, and I had called his name but he did not answer. The CNA walked in to check the bathroom and [Resident #48] was on the floor breathing but not responding to verbal commands. EMS (Emergency Medical Services) was called. While EMS was transferring [Resident #48] from the floor to the stretcher, [Resident #48] then coded (did not have a heartbeat and was not breathing). EMS then performed CPR (Cardiopulmonary Resuscitation) and followed their protocols. When EMS went through all their protocols, they called the ER (emergency room) and the ER doctor then stated to stop CPR. The RN was present and pronounced resident dead at 2035 (8:35pm). RP was here in the facility at the time. MD was called to notify of resident passing. [Funeral Home] picked up resident at 2100 (9:00pm) and RP was here and spoke with [FH person]. No belongings taken at this time, RP stated she would be back to get them. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #48's Standard Assessments in PCC reflected the following: A Postmortem Assessment Effective [DATE] at 9:00pm and signed by LVN D on [DATE] that reflected: A.1. Location resident was discovered: bathroom. 2. How was the resident discovered: on floor. B.1. Advanced Directive. The resident was DNR? YES (That was incorrect, Resident #48 was a Full Code) C. Assessment. Select all that apply: box a. Unresponsive to verbal, tactile, and painful stimuli was the only box checked. The other boxes that were not checked were: box b. No respirations auscultated (heard) with stethoscope at bilateral (both left and right) lung fields, box c. No apical pulse auscultated (no heartbeat heard) with stethoscope and no carotid pulse is palpable, box d. pupils are fixed and dilated, box e. body temperature indicates hypothermia; skin is cold relative to the resident's baseline skin temperature, box f. generalized cyanosis (bluish discoloration of the skin or mucous membranes). D.1. Has an RN pronounced the resident dead: Yes 2. Name of pronouncing RN: RN E 3. Time of death: 8:35pm G.3. Date/time (physician) notified: [DATE] at 8:35pm Date/time (Responsible party) notified: [DATE] at 8:35pm A Postmortem Assessment Effective [DATE] at 9:00pm and signed by LVN D on [DATE] that reflected: Struck out by: LVN D Struck out reason: wrong date/time Struck out date: [DATE] at 5:40pm B.1. The resident was DNR? No (That was correct, Resident #48 was a Full Code) C. Assessment (The information was the same as the above assessment) D.3. Time of death: 8:35am (incorrect) G.3. Date/time (physician) notified: [DATE] at 8:40am (incorrect) Date/time (Responsible party) notified: [DATE] at 8:35pm (correct) A Discharge Summary Effective [DATE] at 9:00pm and signed by the ADON on [DATE] that reflected: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Ridge Rehab & Nursing Center	401 Swift Street Refugio, TX 78377

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.A. Reason for discharge: Resident expired. A.1. Date of discharge: [DATE] 2. Diagnosis at time of discharge: (Resident #48's diagnoses are in the space provided) 3. Brief history: Resident coded while EMS in facility getting ready to transfer to ER. EMS followed their protocol, performed CPR until all measures were taken. ER doctor called off coded and RN E pronounced resident time of death at 8:35pm. 4. Pertinent physical and laboratory findings: None (none of the information about the resident being found on the floor in his bathroom unresponsive nor his fingerstick that was done by the facility prior to EMS arrival and indicated that his blood sugar was low were documented here) 5. Course of treatment: None (The Glucagon administration that was done by the facility prior to EMS arrival was not documented here) This form has the physician's signature and is dated [DATE]. A Discharge Summary effective [DATE] at 9:00pm and signed by LVN D on [DATE] that reflected: Struck out by: LVN D Struck out reason: incorrect documentation. Struck out date: [DATE] at 5:38pm A.A. Reason for discharge: Resident expired at 8:35am (incorrect time) A.3. Brief history: (The same information as the above discharge summary except that it states RN E pronounced resident time of death at 8:35am) A.4. Pertinent physical and laboratory findings: N/A (none of the information about the resident being found on the floor in his bathroom unresponsive nor his fingerstick that was done by the facility prior to EMS arrival and indicated that his blood sugar was low were documented here) A.5. Course of treatment: None (The Glucagon administration that was done by the facility prior to EMS arrival was not documented here) Record review of Resident #48's EMS report dated [DATE] reflected the following information: CLINICAL IMPRESSION Primary impression: Diabetic Hypoglycemia Chief complaint: Fall Patient's level of distress: Severe (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Signs and Symptoms: Hypoglycemia (primary) Injury: Falls- Fall, unspecified- 0 ft - Nursing home [DATE] Mechanism of injury: Blunt Medical/Trauma: Medical Barriers of care: Unconscious Alcohol/ drugs: None reported Initial patient acuity: Emergent VITAL SIGNS 7:52pm AVPU: U (Unresponsive) BP: ,d+[DATE] P: 84 SpO2: 69% BG: LOW GCS: 6 ASSESSMENTS [DATE] at 7:51pm Mental status: unresponsive Skin: cold Eyes: left pupil 6mm non-reactive, right pupil 6mm non-reactive NARRATIVE (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Medic unit] dispatched to [Facility] for elderly male who fell , is unresponsive but breathing. [Medic unit] responded code 3 (lights and sirens) to scene. AOSTF (arrived on scene to find) 74 Y/O Male laying on his right side next to the commode in his room. Nursing home staff stated that fall was unwitnessed, also that his BGL read low. Nursing home staff had administered 1mg of Glucagon prior to arrival. Patient's ABC's patent, slow/snoring respirations noted, unresponsive, skin cool and dry, vomit noted near patient's face. No deformities, contusions, abrasions, punctures, burns, tenderness, lacerations, or swelling noted. Patient placed on monitor, blood pressure cuff and pulse ox. BGL checked by EMS, read low. IV established to (left antecubital with a 20 gauge intravenous catheter). Patient administered D10 drip (10% dextrose (sugar) solution in water- used to help increase a person's blood sugar) wide open rate. Patient moved from original position to supine. Patient placed on soft c-collar (device used to stabilize the neck), slid on to vacuum mattress. Patient secured and carried to stretcher. Upon placement on stretcher, patient was not breathing. No pulse detected; immediate CPR performed. Patient moved from stretcher to floor. Patient placed on EKG pads (electrocardiogram pads), asystole noted via manual interpretation. Epi 1:10,000 (Epinephrine- a medication used to help restart the heart) administered every 4 minutes as per protocol. I-gel (a tube that is put into the airway to assist with giving oxygen) placed in patient airway, size 4 with supplemental high flow oxygen, along with in-line ETCO2 (end tidal carbon dioxide- used in conjunction with oxygen when doing CPR), LR (lactated ringers- a solution used to help rehydrate a person) administered IV (intravenously). PEA (pulseless electrical activity- the heart is giving off electrical signals but is not beating) noted during rhythm checks, CPR continued. After fourth round of Epi, online medical control contacted, [ER doctor] gave instruction to cease resuscitation efforts. Family on scene. Dispatch contacted, informed of patient status. Family funeral home contacted by dispatch. Patient remained on scene with family and nursing home staff, awaiting arrival of funeral home staff. EOR (End of Report). [paramedic's name]. Added: Once CPR was initiated, patient was ventilated manually with BVM (bag valve mask) and supplemental oxygen. Patient respirations managed at a rate of 1 breath every 6 seconds. SPECIALTY PATIENT-CPR Cardiac arrest: yes, after EMS arrival Cardiac arrest etiology: cardiac (presumed) Estimated Time of Arrest: ,d+[DATE] minutes Time 1st CPR: [DATE] at 8:04pm Initial rhythm: Asystole (flat line) End of event: Expired in the field (not in a hospital) Date/Time expired: [DATE] at 8:25pm TIMES Call received: 7:42pm Dispatched: 7:43pm (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	En Route: 7:45pm On scene: 7:47pm At patient: 7:49pm Depart scene: 9:47pm DISPATCHED AS: Fall In an interview on [DATE] at 3:15 PM in the Adm's office with the CN present, the Adm stated that Resident #48 was found unresponsive in the bathroom. The Adm stated it was an unexpected death, but Resident #48 had been refusing a lot of help recently such as refusing labs, refusing medications, and would refuse transfer help some days. The Adm stated that Resident #48 was not on hospice but they had started bringing it up with the family member. The Adm stated, I did not talk to the family member, but we had been discussing bringing it up with her and SOMEONE did discuss it with her. I'm not sure who or when. When asked if Resident #48's death should have been reported the CN stated, the death is reportable only if suspicious. They found him unresponsive, called EMS, he coded, CPR initiated, he was pronounced, then released to [the funeral home]. The business office reports deaths through the TULIP website monthly and they usually have until the 5th of the month. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 3:06pm the DON stated that Resident #48 was a frail man, but he was not on hospice or anything, so his death was not expected. The DON stated, I do not remember who called me that night. What was reported to me was, they found him in the bathroom on the floor, he was breathing but not responding. They called 911. EMS came here and as they were getting him ready to transport, he coded, and I believe EMS started CPR. I don't know anything else about his death. The DON stated that Resident #48 needed assistance to get up to his wheelchair. The DON stated that the nurse who called her said they did not find any injury. The DON stated that she did not recall that they mentioned anything else. When asked about the documentation, the DON stated, the cardinal rule: if you don't document- it didn't happen. When asked what her expectation was the DON stated she would like to see more progress notes done with better detail. The DON stated Resident #48's death should have been documented as soon as possible but definitely before the end of the shift. The DON stated she would need to ask the ADON about the documentation because she thought the ADON had to call LVN D in to do the postmortem assessment because LVN D did not know how to do it. The DON stated that LVN D was the nurse in that hall that night. RN E was working that night but was not in that hall, but it had to be an RN to pronounce. The DON stated that they did check his blood sugar but did not tell her what it was. The DON stated they also did a full set of vital signs. The DON stated, I would have expected them to document that they checked his sugar or gave him Glucagon prior to EMS arrival. The DON stated she was going to have to do a lot of education and reeducation with the nurses on documentation. The DON stated it was important to document things immediately or as soon as possible because by not documenting Resident #48's morning blood sugar or that it was checked, and glucagon given that evening could call into question what actually happened that day. When asked if the death was investigated by the facility, the DON stated there was not an investigation on this death. The DON stated that the CN looked into it because the Adm reported it to corporate. The DON stated, I don't know why it wasn't reported to state. Now, I feel like I should have called it in. It was an unwitnessed fall, and he was unconscious. If they do follow some type of algorithm, I don't know about it. In an interview on [DATE] at 4:36pm in the Adm's office with the Adm present, when asked about Resident #48's status when he was found in the bathroom, the CN stated that Resident #48 was responsive, just not to verbal. When asked if unresponsive meant the same as not responsive, the CN clarified that Resident #48 was unresponsive, but he was breathing. When asked if Resident #48 being on the floor in his bathroom meant that he had sustained an unwitnessed fall, the CN stated, I'm not sure if he had a fall. I would not assume that he did. I can just go by what I see in the chart and what I see documented. When asked if a resident that was found unresponsive after a fall should have been reported the CN stated, I'm still saying no it did not need to be reported. When asked if she concurred, the Adm stated, I concur. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 4:54pm, CNA F stated yes, she remembered Resident #48 and she was working the night he passed away. CNA F stated dinner was usually right at 6:00pm when the night shift arrived and at about 6:,d+[DATE]:40pm they started getting trays out of the rooms. CNA F stated Resident #48 usually ate in his room and that evening his tray was in the room, but she did not check the tray to see if he had eaten dinner. CNA F stated that Resident #48 had gotten to where he would not eat much, and they would give him a snack and/ or juice around 10:00pm because the nurse would say Resident #48's blood sugar was low. CNA F stated that CNAs did not check blood sugars. CNA F stated Resident #48's rolling walker was right before you got to the bathroom in his room. CNA F stated that she found Resident #48 in the bathroom and stepped out of the room to get LVN D, who went in right away. CNA F stated Resident #48 was on his right side with his head was toward the corner of the bathroom. (Bathroom is roughly 6ft wide by 9ft long.) CNA F stated Resident #48's pants were partway down with urine and feces (diarrhea) on the floor and a moderate amt of brown vomit by his face. CNA F stated there was no blood that she noticed. CNA F stated that Resident #48 had his tennis shoes on. CNA F stated that LVN D checked Resident #48's vital signs while he was on his side on the floor, but she did not remember if LVN D checked Resident #48's blood sugar. CNA F stated that she did not recall that LVN D gave Resident #48 a shot or anything. CNA F stated that LVN D called EMS. CNA F stated that once EMS got there, she stepped out of the bathroom and into Resident #48's room. CNA F stated that EMS put Resident #48 onto the vacuum mat, suctioned the air out, then moved him to the EMS stretcher in the room by the bed. CNA F stated that she reached down to get the foot stretcher belt and when she looked up they noticed Resident #48 was not breathing so EMS took Resident #48 off the stretcher and put him on the floor. CNA F stated she walked out of the room then because there were ,d+[DATE] EMS people in the room. In an interview on [DATE] at 5:20pm, LVN B stated that their glucometer range was 40 to 219mg/dL and it gets QC'd (quality control checked) every day. LVN B stated she did not work on Monday [DATE] but the last time she saw Resident #48 on Sunday [DATE], he was ok and the same as always. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 5:27pm LVN D stated she did remember Resident #48. LVN D stated, We came on shift at 6:00pm. I was going down the hall passing meds. I went to Resident #48's room, knocked on the door, opened it, called out his name and he did not answer. LVN D stated the door to Resident #48's bathroom was open but she did not think that Resident #48 was in there because the bathroom door was open and he always answered if she called his name. LVN D stated she turned and went into the room across from Resident #48 and got ready to give that resident her pills. LVN D stated CNA F came down the hall and she asked CNA F if she knew where Resident #48 was. LVN D stated that CNA F replied that Resident #48 should be in his room. LVN D stated when she told CNA F that she had checked his room and called his name and he was not in there, CNA F went in and checked and found Resident #48 in the bathroom. LVN D stated that when CNA F told her that Resident #48 was on the floor of the bathroom, she stopped what she was doing and went in there. LVN D stated that Resident #48 was laying on his left side with his face toward the door and it looked like he had thrown up a small amount of brown (not coffee ground or bloody) vomit. LVN D stated she did not remember any urine or feces, just the vomit. LVN D stated they checked Resident #48, and he was still breathing, had a pulse, and his eyes were open. LVN D stated she was calling his name, but he was not responding. LVN D stated Resident #48's pants were halfway on, and he had shoes and socks on. LVN D stated she did check all of Resident #48's vital signs but does not recall what they were. LVN D stated she then called EMS and the doctor to let him know that she was going to send Resident #48 out because it looked like he had fallen, and she was concerned that he may have hurt himself based on how they found him. LVN D stated she checked Resident #48's blood sugar and it was low, but she did not remember what the number was. LVN D stated, I believe I did document it, but I do not remember for sure. LVN D stated Resident #48 had an order for Glucagon, so RN E gave it to him when she (LVN D) went to open the door for EMS. LVN D stated that EMS went to his room and did an assessment and CNA F helped to get Resident #48 dressed. LVN D stated, From that point I remember making a phone call to the family member to let her know we were sending him out and when I went back into the room, they told me that when they were transferring Resident #48 to the stretcher, he had coded. LVN D stated that EMS ran the code and that she did not recall them ever getting a pulse back. LVN D stated that Resident #48 was a very independent person and did most things for himself. LVN D stated Resident #48 had a cane that he used to go from his bed to the toilet, but she did not remember if the cane was in the bathroom. LVN D stated she did not know if Resident #48 ate dinner that evening because she had just gotten on shift. When asked to recap what had happened, LVN D stated, This all started around 7:30ish pm. The CNA (CNA F) was coming down the hall picking up hall trays. I asked her if he (Resident #48) was out front because he didn't answer and she said no, he should be in his room. She probably hadn't picked up his tray yet because she was making her way down the hall picking up trays. After I asked about where he was, she went into the room and found him in the bathroom- the bathroom door was open. Originally, the room door was closed because he always kept it closed. When I stepped in his room, the curtain was back. I didn't think to look for his scooter because he didn't answer me, so I assumed he was up front when he didn't answer. I could see the bed, so I knew he wasn't in the bed. I didn't check the bathroom because the bathroom door was open, and he didn't respond back to me. I don't know if he would normally close the bathroom door because I was not very familiar with him. We didn't move anything out of the bathroom, so I know his scooter wasn't in there. LVN D stated she thought she had documented the blood sugar somewhere, maybe on the transfer papers when she was going to send him out. LVN D stated she was going to check in Resident #48's EHR to see if the blood sugar result was documented anywhere, and at 6:13pm, LVN D stated that she was not able to find the documentation of the blood sugar or the glucagon administration in Resident #48's EHR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on [DATE] at 6:18pm RN E stated she did remember Resident #48 and that she was working the night of his code. RN E stated she was called into Resident #48's room because he was found in the bathroom unresponsive. RN E stated, The first thing that came to my mind was to check his sugar. RN E stated that LVN D told her that Resident #48's sugar was low, so she gave him Glucagon subcutaneously (into the fatty tissue) in his abdomen and as soon as she gave him the injection, EMS was in the room. RN E stated Resident #48 was laying in the corner between the toilet and the wall, he had his head kind of tucked in, so he was more facing the toilet and the back wall by the toilet. RN E stated she did not even know that Resident #48 had coded, but someone told her so she was in the hallway for a little while. RN E stated she was in the room when EMS was using the [NAME] device (a device that does chest compressions automatically so that EMS personnel are able to do other things) on him. RN E stated that EMS called medical control and the ER (emergency room) doctor said to stop CPR. RN E stated she did not remember if she documented the Glucagon or not. RN E stated normally she would document it on the MAR, but everything happened so fast she did not remember if it was documented. RN E stated it was important to document medications that were given to show proof that it was given. RN E stated if medications that were given were not documented, the provider would not know what medications were given, especially if they were PRN (as needed) medications. RN E stated that Resident #48 normally did not go into the bathroom with his scooter, he would ambulate to the bathroom with his 3 wheel walker. RN E stated Resident #48 had fallen a couple of months prior because he would walk really fast with the 3 wheeled walker and wore flip flops. In a telephone interview on [DATE] at 6:35pm LVN G stated she remembered Resident #48 and she was working day shift on [DATE]. LVN G stated she did not remember what his blood pressure was that morning and could not recall if it was lower than normal. LVN G that she did check Resident #48's blood sugar that morning, but I could not recall what it was. LVN G stated normally the result would be documented in the chart in the MAR, but that it had changed so that it was just a check mark for yes it had been checked. LVN G stated she usually kept a log of who she checked sugars on and what they were, but her bag was in her car and her car was in the shop. LVN G stated if Resident #48's sugar had been low she would have gotten him something and called the doctor. LVN G stated Resident #48 was up eating breakfast that morning, he was up in his chair that day, and that he was acting normal and there was nothing out of the ordinary going on for him. LVN G stated she did not know if Resident #48 ate lunch because he ate in his room, and she was in the dining room at lunchtime. LVN G stated it was important to make sure that things were documented so that everyone knew what had or had not been done. LVN G stated, If it wasn't documented, it wasn't done is what we were taught in school. I feel bad that I didn't document it, but if it had been low, I would have done something about it and called the doctor. LVN G stated it was important to document the blood sugar results so that the physician was able to see how they were trending and [NAME] able to treat the resident accordingly. LVN G stated usually if Resident #48 felt like his sugar was getting low he would ask her to check his sugar and/or ask for an orange juice. In an interview on [DATE] at 11:53am, the DON stated they had started a 100% check on all of the diabetic residents and residents that had blood sugar checks to make sure that there was a place to document the blood sugar results on the MAR. The DON stated that the issue with Resident #48's blood sugar results not having a space on the MAR was because when the physician changed the order to check it to two times a day, he did not check off the box on the order that required it to be documented in the MAR. The DON stated that they were going to make sure that all of the orders for blood sugar checks had that box checked off. Record review of the facility's Documentation policy dated 2003 reflected in part: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software Point Click Care (PCC). Goal 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed. 6. Document completed assessments in a timely manner and per policy. 7. Complete documentation in the electronic health record in a timely manner. Each entry will be dated and timed. Each entry will be signed with proper signature and title. If PCC is used for the assessment the signature and title of the person entering the information will be signed by entering their password. 8. Documentation during and following an acute episode, following an event, and during physiologic, mental, or emotional Changes or instability.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for two (Resident #16 and Resident #43) of 4 residents reviewed for infection control practices. 1. The facility failed to ensure LVN B kept Resident #16's open wounds from coming in contact with a soiled surface. 2. The facility failed to ensure LVN A utilized EBP while flushing and giving medications through Resident #43's g-tube. These failures could place residents that require wound care at risk for healthcare associated cross-contamination and infections. The findings included: 1. Record review of Resident #16's face sheet dated 11/6/24 reflected an [AGE] year-old-male with an original admitted [DATE]. Diagnoses included dementia (cognitive decline that affects memory, thinking, and daily activities), congestive heart failure, type 2 diabetes (insufficient production of insulin in the body), liver disease, and peripheral vascular disease (narrowing of arteries that reduce blood flow to the arms and legs). Resident #16 had a sacrum/gluteal (base of spine/buttocks), cleft/buttocks (groove between the buttocks) cluster wounds. Record review of Resident #16's care plan dated 10/31/24 revealed: Resident #16 had a pressure ulcer. Interventions included: Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings as needed. Record review of Resident #16's MDS dated [DATE] reflected a BIMS score of 7 (indicated severe cognitive impairment) and had moisture associated skin damage. During a wound care observation on 11/05/24 at 04:30 PM Resident #16 was observed rolling back onto his soiled brief multiple times throughout wound care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676491	A. Building B. Wing	11/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Ridge Rehab & Nursing Center	401 Swift Street Refugio, TX 78377

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/05/24 at 04:39 PM LVN B stated she was nervous and did not realize Resident #16's wounds were touching the soiled brief. LVN B stated Resident #16's wounds should not have come in contact with the soiled brief as the wounds could get infected. LVN B stated exposing the open wounds to a soiled surface was cross-contamination and could result in slower healing. LVN B stated she used to be a wound care nurse but did not have any specialized training or certifications. LVN B stated administration had not conducted wound care competency checks and she could not remember when the last in-service on wound care was. In an interview on 11/06/24 at 08:48 AM the DON stated Resident #16's wounds should not be touching other soiled surfaces since it could cause an infection and possibly delay healing. The DON stated Resident #16 was at a higher risk for infection and increased skin breakdown due to the cross contamination. The DON stated the last in-service on infection control was about a week ago but will immediately in-service staff on infection control. The DON stated she had not done competency checks on wound care but would start that process and was going to in-service staff on infection control immediately. 2. Record review of Resident #43's face sheet dated 10/12/24 reflected a [AGE] year-old male with an original admitted [DATE], and an initial admitted [DATE]. Diagnoses included Giardiasis 10/12/24 (a common parasitic intestinal infection causing diarrhea and prevalent in areas with poor sanitation and unsafe water), Methicillin Resistant Staphylococcus (a type of bacteria that is resistant to many antibiotics; a staph infection that does not respond well to the antibiotics that usually treat staph infections), Gastrostomy 09/13/24 (a surgically placed tube that provides access to the stomach for feeding. Latin for stomach and new opening), Enterocolitis (inflammation of the small intestine) r/t clostridium difficile 09/12/24 (a highly contagious bacterium and a leading cause of diarrhea worldwide that is associated with antibiotics), gastro-esophageal reflux disease, chronic respiratory failure due to pneumonia 08/22/24 or aspiration pneumonia 04/24/24 (inhalation of food and vomit), malnutrition, unspecified dementia, stroke 04/24/24 with subsequent memory and cognitive deficits, aphasia (a language disorder that can cause a person to lose the ability to speak, understand language, or both. It is caused by damage to specific regions of the brain, usually from a stroke or head trauma), and dysphagia (the muscles used for swallowing do not work properly, making it difficult or impossible to safely swallow food, liquids, or saliva. It is commonly caused by a stroke). Record review of Resident #43's quarterly MDS revealed a BIMS score of 01, indicating severe cognitive impairment. He was total care requiring maximal assistance for all functional abilities. He was incontinent of bladder and bowel. His active diagnosis was medically complex conditions. He was receiving an anticoagulant and antibiotics. Record review of Resident #43's most recent care plan dated 10/15/24 and revised on 11/02/24 revealed Resident #43 was on enhanced barrier precautions Date Initiated and revised: 09/25/2024. There will not be any transmissions of infection from or to the resident Date initiated: 09/25/24. Gloves and gown should be donned if any of the following activities were to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, bathing, or other high-contact activity. Date Initiated: 09/25/2024. Posting at the resident's room entrance indicating the resident was on enhanced barrier precautions. Date Initiated: 09/25/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of LVN A at Resident #43's bedside on 11/04/24 at 1:33 PM revealed LVN A wore gloves but did not utilize any other EBP when administering medication via Resident #43's g-tube. There was no signage on or near the door, but there was a container with gowns, face shields, and gloves outside of Resident #43's room. In an interview with LVN A on 11/04/24 at 1:33 PM, she said the staff exercised EBP at this facility. She said she did not know she was supposed to wear a gown, gloves, and use a face shield while performing a medication pass via g-tube. She said EBP was to be used with any open wounds, urinary tract infections, and any kind of contact isolation. She said she received education about EBP during her re-orientation on 11/04/24. In an interview with the DON on 11/06/2024 at 9:06 AM, she said they utilized EBP at the facility. She said the facility currently had 8 residents with EBP and she just did an in-service. She said EBP was used for residents who had higher risks for infection because they were already compromised. She said the facility guidelines indicated using EBP for any indwelling catheter, chronic wounds, g-tubes, central lines, or colonized MDROs (Multi Drug Resistant Organisms). She said the process to initiate EBP was to place a sign on the resident's door and educate staff on gowning up when doing high acuity care such as incontinent care, touching, or any contact. She said g-tubes were an opening; a wound so the residents with g-tubes were susceptible to cross-contamination and infection. She said she and the ADON were monitoring residents who were on EBP. She said they did so by checking the dashboard (EHR) for nurses and in the assignment book for the CNAs and nurses. The DON said EBP was supposed to be in the care plans and point of care for CNAs. She said they also observed resident rooms for signs on the door, PPE outside the rooms, and if staff were actually doing it during their daily morning rounds. She said LVN A had not been working at the facility for about 3 months and was recently re-hired on Monday, 11/04/24. She said LVN A should have known better about the medications and the EBP. She said LVN A had electronic on-boarding and she needed to get with HR to see what exactly was in there for new hires. She said EBP was a part of orientation as well as g-tube medication administration. She said orders were not required for EBP but were found in the task section of the EHR. In an interview with corporate HR on 11/06/24 at 10:56 AM, he said g-tube medication administration was not part of the new hire orientation. It was a 3-day training once the nurse started working on the floor. He said he could not find LVN A's g-tube training. In an interview with HK on 11/07/24 at 1:48 PM, she said she was not familiar with what EBP meant. She said isolation of some kind was when residents had the sign outside the room and the PPE cart. She said residents could have something contagious and she did not want to spread it. She said she would still gown up if there was a cart but no sign. She said she did not have any training on EBP, but she knew to read the signs and look for carts if someone was on isolation. (continued on next page)

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