STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676494	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebonnet Point Wellness	151 Heritage Springs Drive Bullard, TX 75757

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on interview and record review, the facility failed to ensure the resident and/or representative had the right to participate in the development and implementation of his or her person-centered plan of care, for 1 of 4 residents (Resident #1) reviewed for the right to participate in planning care. The facility failed to ensure Resident #1, or the resident's representative were invited to participate in the residents' care plan meeting. This failure could place residents at risk for not receiving adequate or individualized care. Findings included: Record review of Resident #1's face sheet, printed on 07/29/24 indicated she was an [AGE] year-old female who admitted to facility on 05/23/24 and discharged from facility on 07/11/24 to acute care hospital with diagnoses including Rheumatic aortic insufficiency (a form of valvular heart disease, occurs when the aortic valve of the heart leaks and causes blood to flow in the wrong direction. As a result, the heart cannot pump efficiently, causing symptoms like fatigue and shortness of breath), hypertension (High blood pressure is when the force of blood pushing against your artery walls is consistently too high), Orthostatic hypotension (also known as postural hypotension, is a type of low blood pressure that occurs when blood pressure drops when standing up from a sitting or lying position), Peripheral vascular disease (is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel) and Anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of admission MDS assessment date 05/29/24 indicated Resident #1 had a BIMS score of 9, which indicated moderately impaired cognition. She required Substantial/maximal assistance in performing most activities of daily living. Record review of a baseline care plan for Resident #1 indicated it was completed on 05/23/24. Record review of Resident #1's comprehensive care plan reflected it was dated 06/06/24. There was no documentation on the care plan that the resident/resident representative was notified of a care plan meeting. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's EMR, from 05/23/24 through 07/11/24, reflected no documentation there had been any care plan meetings for the time Resident #1 had been at the facility or that the resident/resident representative was notified of a care plan meeting. Record review of email dated 06/24/24 from Resident #1's family member and the facility's SW revealed the following: Would you (SW) mind telling me (Resident #1's family member) who the doctor is over [Resident #1] and could you (SW) please tell me (Resident #1's family member) what medical plan is in place for her. Also, what is the facility's policy for notifying me (Resident #1's family member) of changes in [Resident #1's] day to day medical work up. Record review of email dated 07/05/24 from Resident #1's family member to the facility SW revealed the following: To recap our conversation: -Setting up a medical care plan is not something the facility do, and [Resident #1] will remain on the orders [Resident #1] came with from hospice. -The facility's only plan is to keep [Resident #1] comfortable during her time at the facility, and a care plan will not be established. During an interview on 08/09/24 at 3:38 p.m., SW said Resident #1's family member emailed and called her a few times regarding Resident #1's care. SW reviewed the 06/24/24 and the 07/05/24 paper copy emails from Resident #1's family member to SW questioning if facility had a care plan and requesting setting up a medical care plan meeting. SW said she had been working as the facility's SW since May under supervision of a licensed SW, and in 07/2024 she passed her SW license exam and became the full time SW. She said in July 2024 she was doing the best she could with answering Resident #1's family member's questions and during 07/2024 the facility was going through a change of ownership and changes with department heads staff. SW said Resident #1 family member kept asking for medical plan and she said she explained to Resident #1's family member the facility did not have medical plans but did have care plans. SW said she was responsible for setting up the care plan meetings, but at that time she was still learning, and she did not know the process for setting up the meetings and she chose not to ask anyone for help, and she never set up a care plan meeting for Resident #1, or the resident's representative. SW said she did not forward Resident #1's family member's emails to the administrator, nor notified the Regional Compliance Nurse regarding Resident #1's family member's concerns. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/09/24 at 6:50 p.m., MDS Coordinator B said in May 2024 she was assisting with doing and sending out care plan meeting notices. She said she kept documentation of each care plan meetings in a planner she used to schedule and keep up with the upcoming care plan meetings. She reviewed her planner and did not see Resident #1's name in her planner. She said by the time Resident #1 admitted they had already sent out the May notices for upcoming care plan meetings and she never sent out a care plan meeting notice to Resident #1's family representative or to Resident #1. MDS coordinator B said she needed to do Resident #1's admission MDS assessment and met with Resident #1 on 05/29/24 by herself at bedside to complete the Admission MDS and that was like a care plan meeting. She said residents and/or family have the right to be invited and participate in the development of the care plans . She said the meetings are quarterly or after admission. MDS Coordinator B said the dietary managers, social worker, CNA, activity director, family, resident and if a resident was on hospice services, then hospice representative normally attends the care plan meetings, but she did not do that with Resident #1 because she was just trying to get the admission MDS completed timely. Record review of undated comprehensive care planning policy 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 .Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. The facility will establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives . A comprehensive care plan will be developed within 7 days after completion of the comprehensive assessment. -Prepared and/or contributed to by an interdisciplinary team that includes but is not limited to - the attending physician - A registered nurse with responsibility for the resident. -A nurse aide with responsibility for the resident -A member of food and nutrition service staff - To the extent practicable, the participation of the resident and the resident's representative(s). An explanation will be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan .Facility staff will assist residents to engage in the care planning process, helping residents and resident representatives, if applicable understand the assessment and care planning process; holding care planning meetings at the time of day when the resident is functioning best; planning enough time for information exchange and decision making; encouraging a resident's representative to participate in care planning and attend care planning conferences. The facility will provide the resident and resident representative, if applicable, with advance notice of care planning conferences to enable resident/resident representative participation. Resident and resident representative participation in care planning can be accomplished in many forms such as holding care planning conferences at a time the resident representative is available to participate, holding conference calls or video conferencing.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on observation interview and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 4 residents reviewed for grievances. (Resident #1) The facility did not investigate or take prompt action to resolve grievances voiced by Resident #1's family member on behalf of Resident #1 These failures could place residents at risk for grievances not being addressed or resolved promptly. Findings included: Record review of Resident #1's face sheet, printed on 07/29/24 indicated she was an [AGE] year-old female who admitted to facility on 05/23/24 and discharged from facility on 07/11/24 to acute care hospital with diagnoses including Rheumatic aortic insufficiency (a form of valvular heart disease, occurs when the aortic valve of the heart leaks and causes blood to flow in the wrong direction. As a result, the heart cannot pump efficiently, causing symptoms like fatigue and shortness of breath), hypertension (High blood pressure is when the force of blood pushing against your artery walls is consistently too high), Orthostatic hypotension (also known as postural hypotension, is a type of low blood pressure that occurs when blood pressure drops when standing up from a sitting or lying position), Peripheral vascular disease (is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel) and Anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of admission MDS assessment date 05/29/24 indicated Resident #1 had a BIMS score of 9, which indicated moderately impaired cognition. She required Substantial/maximal assistance in performing most activities of daily living. A record review of the facility's grievance records dated 05/23/24 through 08/09/24 revealed no there was no documentation of the grievances submitted on behalf of Resident #1. Record review of email dated 06/24/24 from Resident #1's family member and the facility's SW revealed the following: Would you (SW) mind telling me (Resident #1's family member) who the doctor is over [Resident #1] and could you (SW) please tell me (Resident #1's family member) what medical plan is in place for her. Also, what is the facility's policy for notifying me (Resident #1's family member) of changes in [Resident #1's] day to day medical work up. Record review of an email dated 07/05/24 at 5:52pm from Resident #1's family member to the facility SW revealed the following: To recap our conversation: -As far as [Resident #1] having Covid, the facility has no specific care for Covid patients. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Setting up a medical care plan is not something the facility do, and [Resident #1] will remain on the orders Resident #1 came with from hospice. -The facility has no head nurse on staff right now. -The facility doesn't have a therapy team on staff right now. However, when you get one, you will be checking into her possibly getting therapy. -The facility's only plan is to keep [Resident #1] comfortable during her time at the facility, and a care plan will not be established. Resident #1's concern revolved around preventing pneumonia. What proactive steps can we take to ensure pneumonia does not develop during this period? Considering the current staff transition at the facility, would it be feasible to involve an external doctor? Does facility provide external doctors in such cases? Does it sound feasible for Resident #1 to go to a hospital? I (Resident #1's family member) look forward to hearing back from SW after your investigation into things. During an interview on 08/09/24 at 3:38 p.m., SW said Resident #1's family member emailed and called her a few times regarding Resident #1's care. SW reviewed the 06/24/24 and the 07/05/24 paper copy emails from Resident #1's family member to SW questioning if facility had a care plan and requesting setting up a medical care plan meeting. SW said she had been working as the facility's SW since May under supervision of a licensed SW, and in 07/2024 she passed her SW license exam and became the full time SW. She said in July 2024 she was doing the best she could with answering Resident #1's family member's questions and during 07/2024 the facility was going through a change of ownership and changes with department heads staff. SW said Resident #1's family member kept asking for medical plan and she said she explained to Resident #1's family member the facility did not have medical plans but did have care plans. SW said she was responsible for setting up the care plan meetings, but at that time she was still learning, and she did not know the process for setting up the meetings and she chose not to ask anyone for help, and she never set up a care plan meeting for Resident #1, or the resident's representative. SW said she did not forward Resident #1's family member's emails to the administrator, nor notified the Regional Compliance Nurse regarding Resident #1's family member's concerns. The SW said she handled the grievances and at the time she did not consider Resident #1's family member's emails and calls as grievances. SW said she defined grievances at concerns and said now looking back she should have considered the emails and phone calls from Resident #1's family member as a grievance. Record review of an email dated 07/10/24 at 11:08am from Resident #1's family member to Admission Coordinator revealed Can you (Admission Coordinator) please confirm the information that was provided to us (Resident #1' family) regarding: 1- establishing a care plan 2- covid care protocol (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3- proactive measures to ensure prevention and detection of pneumonia in patients tested positive for covid ([Resident #1] has developed a congested cough while in isolation) FYI: I (Resident #1 family member) have tried several times to contact [Resident #1]'s current nurse for updates and the concern about her coughing to no avail. Resident #1's family member attached email sent receipt dated 07/05/24 at 5:52pm from her to the SW as evidence. During an interview on 08/09/24 at 3:56 p.m., the Admission Coordinator said the email from Resident #1's family member was her first time being notified by Resident #1's family member about Resident #1's care and said she forward the email to the Regional Compliance Nurse to follow up with Resident #1. Record review of email dated 07/10/24 at 11:13am from Admission Coordinator to Resident #1's family member revealed will forward this to our director. During an observation and interview on 08/09/24 at 5:08 p.m., with the Regional compliance nurse, she said her first time being notified regarding Resident #1's family members list of concerns was whenever the Admission Coordinator forward her the emails from Resident #1's family member. The Regional compliance nurse said she reached out to Resident #1's family member immediately and was able to address several of her concerns. She said Resident #1's family member told her a lot of things could have been resolved a long time ago, but no one would get back with her or did not know the answer. The Regional compliance nurse said the SW had been notifying her on everything else and did not know why the SW did not notify her regarding Resident #1's family members concerns or why SW told Resident #1's family member the facility did not have a head nurse because she had been working as the head nurse since July 1, 2024, whenever the new company took over. During an observation of facility, there was no postings in a prominent location to notify residents on how to file a grievance orally, in writing, or anonymously. Record review of revised grievance policy dated 11/2/2016 revealed The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. 1. The facility will notify residents on how to file a grievance orally, in writing, or anonymously with postings in prominent locations .8. Maintain evidence demonstrating the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission and provide the resident and the resident representative with a summary of the baseline care plan for 2 of 4 residents reviewed for the base line care plans. (Resident #s 1 and 2). The facility did not provide a written summary of the baseline care plan to Residents #1 and #2 or their responsible party. The facility did not complete a baseline care plan within 48 hours of admission for Resident #2. This failure could place newly admitted residents at risk for services not being provided as needed. Findings included: 1)Record review of Resident #1's face sheet, printed on 07/29/24 indicated she was an [AGE] year-old female who admitted to facility on 05/23/24 and discharged from facility on 07/11/24 to acute care hospital with diagnoses including Rheumatic aortic insufficiency (a form of valvular heart disease, occurs when the aortic valve of the heart leaks and causes blood to flow in the wrong direction. As a result, the heart cannot pump efficiently, causing symptoms like fatigue and shortness of breath), hypertension (High blood pressure is when the force of blood pushing against your artery walls is consistently too high), Orthostatic hypotension (also known as postural hypotension, is a type of low blood pressure that occurs when blood pressure drops when standing up from a sitting or lying position), Peripheral vascular disease (is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel) and Anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of a baseline care plan for Resident #1 indicated it was completed on 05/23/24. There was no documentation on the care plan that the resident/resident representative was provided a summary of the base line care plan. Record review of Resident #1's clinical records from 05/24/24 through 07/11/24, revealed there was no documentation that the resident/resident representative was provided a summary of the base line care plan. 2) Record review of Resident #2's face sheet, printed on 08/07/24 indicated she was a [AGE] year old female who admitted to facility on 06/21/24 and discharged from facility on 06/27/24 with diagnoses including Hemiplegia affecting left nondominant side (paralysis on left side of the body due to an injury to the brain or spinal cord), hypertension (High blood pressure is when the force of blood pushing against your artery walls is consistently too high), and Gastroesophageal reflux disease without esophagitis (also known as non-erosive reflux disease (NERD), can occur when stomach acid flows back up into the esophagus without damaging it). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a baseline care plan for Resident #2 indicated it was completed late on 06/26/24 and there was no documentation on the care plan that the resident/resident representative was provided a summary of the base line care plan. Record review of Resident #2's clinical records from 06/21/24 through 06/27/24 revealed there was no documentation that the resident/resident representative was provided a summary of the base line care plan. During an interview on 08/09/24 at 3:13 p.m., and at 4:21 p.m., the Regional Compliance Nurse said effective 07/01/24 her company took over the facility. She said she was not aware if the previous company was requiring the facility to provide copies of the care plans to the resident or their responsible party. The Regional Compliance nurse said she would have to reach out to the previous company and ask who was responsible for doing the baseline care plans and for any documentations. She said the previous DON and previous ADONs who no longer worked at the facility were possibly responsible for the baseline care plans. The Regional compliance nurse said she spoke with the previous company, and they did not have any documentation in clinical records indicating that the resident/resident representative was provided a summary of the initial care plan. She said since her company took over 07/01/24 the charge nurses had the ability to initiate baseline care plans and provide copies. Record review of undated base line care plan policy indicated Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. The baseline care plan will be developed within 48 hours of a resident's admission.

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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. 35340 Based on observation, interview and record review, the facility failed to ensure medications were stored in locked compartments and permit only authorized personnel to have access to the keys on 1 of 2 medication carts reviewed for drug labeling and storage,. (Hall 100 Medication Aide Cart) -Medication Aide Cart for Hall 100 was left unlocked, unsecured, and unattended on Hall 100. This failure placed residents at risk of drug diversion and access to and ingestion of medications not prescribed for them. Findings included: During an observation on 08/09/24 at 7:16 p.m., the Medication Aide Cart for Hall 100 was unlocked, and unattended stored against the wall on Hall 100 for unknown amount of time. All the drawers of the medications cart could be opened, and the medications were easily accessible. A resident was observed passing by the medication cart. During an interview on 08/09/24 at 7:18 p.m., MA C said she had just finished passing medications on the 100 hall and was ready to leave and without thinking she walked off to find a nurse to count medications with and she made a mistake because the medication cart should be locked every time she walked away from the cart. During an interview on 08/09/24 at 8:23 p.m., the Regional Compliance Nurse said she expected all medication carts to be locked when unattended. Record review of undated medication storage policy indicated Medications and biologicals are stored safely, securely, and properly following manufacturers recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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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** 35340 Based on interview 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 of 6 residents reviewed for accuracy and completeness. (Resident # 1) The facility failed to accurately complete Resident # 1's comprehensive care plan. This failure could place the residents at risk for incomplete and inaccurate clinical records which could lead to miscommunication, a delay in services or a potential decline in resident's health. Findings included: Record review of Resident #1's face sheet, printed on 07/29/24 indicated she was an [AGE] year-old female who admitted to facility on 05/23/24 and discharged from facility on 07/11/24 to acute care hospital with diagnoses including Rheumatic aortic insufficiency (a form of valvular heart disease, occurs when the aortic valve of the heart leaks and causes blood to flow in the wrong direction. As a result, the heart cannot pump efficiently, causing symptoms like fatigue and shortness of breath), hypertension (High blood pressure is when the force of blood pushing against your artery walls is consistently too high), Orthostatic hypotension (also known as postural hypotension, is a type of low blood pressure that occurs when blood pressure drops when standing up from a sitting or lying position), Peripheral vascular disease (is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel) and Anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of facility notification of hospice admission/change form dated 05/23/24 indicated Resident #1 admitted on [DATE] to facility on Respite services effective 05/23/24 to 05/27/24. Record review of revocation of hospice care Medicare/Medicaid patient form dated 05/30/24 indicated Resident #1 and family member selected to seek aggressive treatment and no longer desired hospice services effective 05/30/24. Record review of Resident #1's comprehensive care plan dated 06/06/24 indicated Problem/Need: Hospice; Goal: Nursing home and hospice will work together to provide optimal care for resident in next 90 days; Approaches: -Nursing staff will notify hospice of any changes in condition. - Provide comfort care. -Hospice RN/LPN visit per hospice protocol. -Hospice CNA to visit per hospice protocol. - Hospice social worker to visit per hospice protocol. - Hospice clergy to visit per hospice protocol. During an interview on 08/02/24 at 12:15 p.m., BOM said Resident #1 admitted from home with Hospice for a short term Respite stay; but Resident #1's family was wanting Resident #1 to start physical therapy and that was why they ended Hospice services effective 05/30/24 and stayed at the facility as private pay from 05/31/24 to 06/30/24 and was Medicaid Pending effective 07/01/24 to time of discharge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676494	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebonnet Point Wellness	151 Heritage Springs Drive Bullard, TX 75757

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/09/24 at 6:50 p.m., MDS Coordinator B said she did Resident #1's comprehensive care plan on 06/06/24 and said Resident #1 was not on hospice services during that time. MDS Coordinator B said she did not realize she added Hospice to Resident #1's care plan and said it was a mistake and should not have been on Resident #1's care plan. During an interview on 08/09/24 at 6:57 p.m., and at 8:23 p.m., the Regional Compliance Nurse said they did not have a specific policy regarding maintaining residents' clinical records (accuracy) , but she expected for care plans to be accurate and reflect the resident's current status/needs.