STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676497	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health and Wellness	110 N State Hwy 274 Kemp, TX 75143

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview, and record review, the facility failed to ensure the residents' rights to formulate an advance directive for 2 of 23 residents reviewed for advanced directives. (Residents #66 and #225) 1. The facility failed to ensure Resident #66's OOH-DNR was completed accurately. 2. The facility did not ensure Resident #225 had a physician order for her preferred code status. 3.The facility did not ensure Resident #225's code status was readily available to facility staff. These failures placed the residents at risk of not having their end of life wishes honored. Findings included: 1. Record review of Resident #66's face sheet dated [DATE], indicated an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included fracture of right lower leg, diabetes type 2 (long term condition in which the body has trouble controlling blood sugar and using it for energy), hypertension (high blood pressure), and dementia (memory loss). The face sheet indicated under the advance directive section **Code Status: DNR**). Record review of Resident #66's admission MDS assessment dated [DATE], indicated Resident #66 was able to make herself understood and understood others. The MDS assessment indicated Resident #66 had a BIMS score of 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #66 required partial/moderate assistance with toileting, showering, lower body dressing and putting on/taking off footwear. Record review of Resident #66's comprehensive care plan dated [DATE], indicated Resident #66 wished her code status to be DNR with interventions to discuss a code status at care plan conferences and to send a copy of DNR with resident to outside appointments/hospital transfers. Record review of Resident #66's physician's orders dated [DATE], indicated Resident #66 had an order for Code Status: DNR with a revised date of [DATE]. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #66's OOH-DNR dated [DATE], revealed the witnesses had only signed in the section where it indicated Two Witnesses. The witnesses had not signed at the bottom of the form under where the OOH-DNR form instructed . All persons who have signed above must sign below, acknowledging that this document has been properly completed. During an interview on [DATE], at 3:01 PM, the SW said she was responsible for ensuring the DNRs were completed. The SW said based on the DNR instructions the witnesses do no need to be sign at the bottom of the form. The SW said when she was trained, she was only informed the witnesses had to sign on the section where it indicated the two witnesses. During an interview on [DATE] at 11:48 AM, the DON said she was unsure of the how the DNR needed to be completed. The DON said the SW was responsible was for ensuring the DNRs were accurately completed. The DON said not having Resident #66's DNR accurately completed could cause the nurse to have confusion on what to do in a life-or-death situation. During an interview on [DATE] at 11:49 AM, the Administrator said the DNR form should be completed with whatever the form required. The Administrator said by not completing the form appropriately they were out of compliance with the form requirements. The Administrator said the SW was responsible for completing the DNRs correctly. 47006 2. Record review of the face sheet, dated [DATE], revealed Resident #225 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors), schizoaffective disorder, bipolar type (a mental illness that is generally characterized by a combination of schizophrenic and mood disorder symptoms), traumatic brain injury (brain injury that is caused by an outside force), and heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). The face sheet did not address Resident #225's preferred code status or advanced directive. Record review of the entry MDS assessment, dated [DATE], revealed Resident #225 recently admitted to the facility on [DATE] from an in-patient psychiatric facility. Record review of Resident #225's baseline care plan, dated [DATE], did not address her preferred code status or advanced directive. Record review of the order summary report, dated [DATE], revealed Resident #225 had no physician order for her preferred code status or advanced directive. During an interview on [DATE] beginning at 9:45 AM, the Social Worker stated a code status assessment was one of the first things completed on a resident who admitted to the facility. The Social Worker stated a code status assessment was completed on Resident #225, which indicated she requested a full code status at the facility. The Social Worker stated nursing staff was responsible to making sure a physician order was placed in the electronic medical record. The Social Worker stated nursing staff was also responsible for ensuring the code status was placed on the face sheet, which then showed on the resident status bar in the electronic medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] beginning at 12:33 PM, LVN A stated when a new resident admitted to the facility, the orders were placed in the electronic monitoring system. LVN A stated admission orders should have included an order for the preferred code status. LVN A stated she was unsure the nurse who admitted Resident #225. LVN A stated the order for full code status could have been missed for Resident #225 because the order was not part of the admission batch orders and had to placed into the computer separately. LVN A stated the resident status bar in the electronic medical record was how the nursing staff quickly determined the resident's code status. LVN A stated it was important to ensure the preferred code status was placed in the physician orders and on the face sheet, which pulls to the resident status bar in the electronic medical record so the nursing staff could quickly determine the code status of Resident #225 in an emergency. During an interview on [DATE] beginning at 1:21 AM, the ADON stated the admitting nurse was responsible for making sure a physician order was placed in the electronic medical record for the preferred code status. The ADON stated the preferred code status should have also been placed on the face sheet, which would then show on the resident status bar in the electronic medical record. The ADON stated the resident status bar in the electronic medical record was what the nursing staff looked at to determine a resident's code status. The ADON stated she tried to audit new admission charts within 1 - 2 days but that was not always possible. The ADON stated she had not performed an audit on Resident #225's chart. The ADON stated it was important to ensure the preferred code status was placed in the physician orders and on the face sheet so the nursing staff could quickly determine the code status of a resident in an emergency. During an interview on [DATE] beginning at 1:31 PM, the Corporate Regional Nurse provided a policy on Do Not Resuscitate Order. The Regional Nurse stated that was the facility policy on advanced directives. During an interview on [DATE] beginning at 1:37 PM, the DON and Administrator were interviewed together. The DON stated code status should have been included in the admission orders and on the face sheet so the nursing staff could quickly identify the code status of a new resident. The Administrator stated new admissions were discussed in the daily clinical meeting and Resident #225's missing order should have been caught. The Administrator stated it was important to ensure the preferred code status was placed in the physician orders and on the face sheet to respect the resident's wishes. The DON stated it was important to ensure the preferred code status was placed in the physician orders and the face sheet so nursing staff could quickly determine the code status of a resident in an emergency. Record review of the Do Not Resuscitate Order policy, revised [DATE], revealed . A Do Not Resuscitate (DNR) order form must be completed and signed by the attending physician and resident (or resident' legal surrogate, as permitted by State law) and placed in front of the resident's medical record .Use only state-approved DNR forms .in addition to the advanced directive and DNR order form, state-specific forms may be used to specify whether to administer CPR in case of a medical emergency. State-specific forms include .physician orders for life-sustaining treatment .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on observation, interview and record review, the facility failed to ensure residents had a right to personal privacy and confidentiality of medical records for 1 (Resident #22) of 23 residents reviewed for privacy and confidentiality. The facility failed to ensure MA R closed Resident #22's EMR before entering the supply room and leaving the medication cart unattended. This failure could place residents at risk for low self-esteem, loss of dignity and decreased quality of life due to medication administration record being accessible to others. Findings included: Record review of Resident #22's face sheet dated 10/16/2024, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (a group of diseases that result in too much sugar in the blood), bipolar disorder (a mental illness that causes extreme shifts in mood, energy, and activity level), and anxiety (a mental illness that causes excessive and uncontrollable feelings of fear or anxiety that can significantly impair a person's daily life). Record review of Resident #22's MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. The MDS indicated Resident #22 had a BIMS score of 10, indicating moderate cognitive impairment. The MDS indicated she was totally dependent on staff for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. During an observation and interview on 10/16/24 at 9:19 a.m., the medication cart for hall 400 was open, turned toward the hall and Resident # 22's information was visible. There was no staff present. MA R came out of the supply room, and stated she was responsible for leaving the screen with Resident #22 's information open. MA R stated she quickly ran to the supply room and forgot to close the screen. MA R stated it was important to close the EMR screen to protect Resident #22's personal information. MA R stated there could be a risk to Resident #22 if seen her personal information. During an interview on 10/17/2024 at 10:07 a.m., the DON stated she expected the EMR screen to be locked and the resident's information to be kept confidential. The DON stated the nurse was responsible for ensuring the screen was kept locked when not in use. The DON stated by not keeping the screen locked was a privacy and confidentially issue. During an interview on 10/17/2024 at 10:35 a.m., the Administrator stated he expected the MAR screen to be closed when the nurses entered the resident's room or if they left the cart unattended. The Administrator stated it was a HIPPA violation and breech of resident information leaving the screen with resident information up and visible to others. The Administrator stated everyone was responsible for ensuring resident information was kept confidential. Record review of the facility's policy Statement of Resident Rights residents have the right to personal privacy and confidentiality of their personal and clinical records

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 23 residents (Resident #233) reviewed for abuse. The facility failed to ensure RN N did not verbally abuse Resident #233 on 09/21/2024. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of a face sheet dated 10/17/2024 indicated Resident #233 was a [AGE] year-old female admitted to the facility on [DATE] and discharged [DATE] with diagnoses which included displaced spiral fracture of shaft of right tibia (right fracture of the shin bone). Record review of the 5-day MDS assessment dated [DATE] indicated Resident #233 was able to understand others and was understood by others. The MDS assessment indicated Resident #233 had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #233 required partial/moderate assistance with toileting, showering, and lower body dressing and supervision/touching assistance for upper body dressing and oral hygiene and was independent for eating. Record review of Resident #233's care plan with date initiated 09/20/2024 indicated she used anti-anxiety medications related to an anxiety disorder to monitor her every shift and as needed for safety. Record review of Resident #233's progress notes indicated, This nurse was with resident outside for a break. Resident relayed a nurse, yesterday called her a M'Fer when she asked her to lower the temperature of the room. Administrator, DON, Police and resident representative notified. Signed by LVN E. During an interview on 10/15/2024 at 3:09 PM, RN N said she was not an employee of the facility that she was employed through a staffing agency. RN N said she had never had any incidents with anybody at the facility. RN N said she did not know who Resident #233 was. RN N said she had never had any allegations of abuses against her, and she would never abuse or cuss at a resident. RN N said she had not been contacted by the facility regarding the allegation of abuse made against her. During an interview on 10/15/2024 at 5:50 PM, the Administrator said when there was an incident of allegations of abuse incident statements were obtained from the witnesses and perpetrators and the resident involved. The Administrator said he had not attempted to get a witness statement from RN N because she was an agency employee. The Administrator said because RN N was agency staff the DON or the Staffing Coordinator probably attempted to get her witness statement. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 8:47 AM, LVN E said on 09/22/2024 Resident #233 reported to her that RN N had called her a mother fucker, after she asked her to change the temperature of the AC on 09/21/2024. LVN E said she reported it to RN D, the RN supervisor for the weekend, and to the Administrator, DON, and police. During an interview on 10/16/2024 at 9:00 AM, CNA H said he worked on 09/21/2024. CNA H said Resident #233 kept asking the staff to take her to smoke. CNA H said there were multiple staff at the nurses' station, and another staff (unable to recall who the staff was) told Resident #233 they would take her to smoke. RN N told Resident #233 the staff was doing her a mother fucking favor by taking her out to smoke. CNA H said he had not reported this to the Administrator, the abuse coordinator, because multiple staff heard the comment including RN D (CNA H was unable to recall the other staffs' names). CNA H said he believed RN D would handle the situation. CNA H said if there had not been other staff around, he would have reported it to the Administrator because it was verbal abuse. During an interview on 10/16/2024 at 9:13 AM, RN D said she was the RN supervisor the weekend that the incident with RN N and Resident #233 occurred. RN D said Resident #233 did not inform them immediately of the incident with RN N. RN D said Resident #233 notified LVN E the following day. RN D said Resident #233 told LVN E that she had called RN N into her room to adjust the AC 2 times and RN N had called her a mother fucker. RN D said this was the only incident between RN N and Resident #233 she was aware of. RN D said she had not heard RN N tell Resident #233 the staff was doing her a mother fucking favor by taking her out to smoke, and nobody reported this to her. RN D said if she would have heard this, she would have reported it to the abuse coordinator, the administrator, immediately to protect the residents. During an interview on 10/16/2024 at 9:42 AM, the Social Worker said Resident #233's discharge was unplanned, and Resident #233 had been moved to another facility because a nurse had told her I'm tired of turning the air up mother fucker. During an interview on 10/16/2024 at 9:55 AM, Resident #233 said she had asked RN N to adjust the AC for her. Resident #233 said RN N told her, I am getting tired of turning the fucking AC on and off, mother fucker. Resident #233 said RN N had also told her the nurse is doing you a mother fucking favor to take you to smoke. Resident #233 said it made her feel awful. Resident #233 said she did not want to take RN N's time up she knew she was busy. Resident #233 said she was scared of RN N's attitude because she did not know what she (RN N) was going to do next. During an interview on 10/16/2024 at 10:20 AM, the DON said she was notified of the incident that occurred where RN N called Resident #233 a mother fucker by the Administrator. The DON said she did not remember much about the investigation she just remembered that Resident #233 had transferred to a different facility the next day. The DON said she had not reached out to RN N to ask her what happened with Resident #233. The DON said she was not notified about RN N telling Resident #233 the staff was doing her a mother fucking favor by taking her out to smoke. The DON said that should have been reported, and RN N should have been sent home to ensure the residents were safe and did not have any emotional distress. The DON said the facility did a lot of training on abuse upon hire and the facility provided frequent in-services on abuse. The DON said for staff that was employed through an agency the agency did their abuse training and checked their backgrounds. The DON said they tried to in-service the agency staff when they gave in-services about abuse and agency staff were present in the facility at the time of the in-service. The DON said she was not sure if RN N had received any abuse training by the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 10:54 AM, the Administrator said on 09/22/2024 Resident #233 was outside with a facility nurse and Resident #233 reported to the facility nurse that an agency nurse called her a mother fucker when she asked her to lower the AC the day before, 09/21/2024. The Administrator said he was able to identify RN N, an agency nurse, by the description provided to him by Resident #233. The Administrator said he did an in-service with the staff; safe surveys were completed with residents who were interviewable and the police were notified. The Administrator said no other claims of verbal abuse were made by the residents. The Administrator said he notified the staffing agency he wanted RN N placed on the do not return list for the facility. The Administrator said he was not notified by CNA H or any of the staff who worked on 09/21/2024 of RN N telling Resident #233 the nurse was doing her a mother fucking favor by taking her out to smoke. The Administrator said he should have been notified immediately of the incident. The Administrator said they were continually monitoring for abuse and neglect daily and in-serviced the facility staff frequently on abuse and neglect. The Administrator said they also performed angel rounds where the department heads had room assignments and every morning they checked on the residents. The Administrator said safe surveys were completed on residents who were able to be interviewed when incidents that were reportable occurred. The Administrator said the abuse training for agency staff was completed by the staffing agency. The Regional Compliance Nurse was with the Administrator during the interview, and she said that when agency staff went to the facility to work there was a training packet the facility should have them complete. The training packet was specifically for agency staff, and it contained abuse training for them. The Regional Compliance Nurse said she did not know if the facility had completed this for RN N. The Administrator said he had reached out to the staffing agency RN N was employed by to get her abuse training, and he would check with human resourced to see if RN N had completed the packet. During an interview on 10/16/2024 at 11:11 AM, the Social Worker said she had done a safe survey with Resident #233 after the incident with RN N. The Social Worker said she had asked Resident #233 what happened with RN N, and Resident #233 said she had asked the nurse to adjust the AC and the nurse said I am tired of turning it up and down m fer. The Social Worker said Resident #233 was upset at the language used by RN N, but she had not said she did not feel safe in the facility. During an interview on 10/16/2024 at 3:35 PM, the Staffing Coordinator said she did not reach out to agency staff for statements. The Staffing Coordinator said she contacted the human resources department of the staffing agency for them to get a statement from the staff involved. The Staffing Coordinator said she had contacted the human resources from the staffing agency where RN N was employed for them to get a statement from her, and to notify them to place RN N on the do not return list for the facility. The Staffing Coordinator said she still had not received a statement from them. During an interview on 10/16/2024 at 3:41 PM, the human resources from the staffing agency said they were notified of the incident that occurred with RN N and Resident #233. They said they had reached out to RN N for a statement, but she still had not provided it. They said the facility had requested RN N be placed on the do not return list for the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Resident Abuse and Neglect Policy 2021, indicated, . Our Facility will not condone resident abuse by anyone, including associates {associates herein refer to covered individuals), staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals .c)Verbal abuse: may be considered to be a type of mental abuse. Verbal abuse is defined as any oral, written, or gestured communication or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. It is language that includes disparaging or derogatory terms to a resident or within their hearing distance, regardless of the resident's age, ability to comprehend., or disability .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 1 of 23 residents (Resident #233) reviewed for abuse. The facility failed to implement their policy on reporting abuse when CNA H did not immediately report RN N's verbal abuse towards Resident #233 on 09/21/2024. The facility failed to follow its policy when RN N did not complete abuse training. These failures could place residents at risk of unreported abuse, neglect, exploitation, and a decreased quality of life. Findings included: Record review of a face sheet dated 10/17/2024 indicated Resident #233 was a [AGE] year-old female admitted to the facility on [DATE] and discharged [DATE] with diagnoses which included displaced spiral fracture of shaft of right tibia (right fracture of the shin bone). Record review of the 5-day MDS assessment dated [DATE] indicated Resident #233 was able to understand others and was understood by others. The MDS assessment indicated Resident #233 had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #233 required partial/moderate assistance with toileting, showering, and lower body dressing and supervision/touching assistance for upper body dressing and oral hygiene and was independent for eating. Record review of Resident #233's care plan with date initiated 09/20/2024 indicated she used anti-anxiety medications related to an anxiety disorder to monitor her every shift and as needed for safety. During an interview on 10/15/2024 at 3:09 PM, RN N said she was not an employee of the facility that she was employed through a staffing agency. RN N said she had never had any incidents with anybody at the facility. RN N said she did not know who Resident #233 was. RN N said she had never had any allegations of abuses against her, and she would never abuse or cuss at a resident. RN N said she had not been contacted by the facility regarding the allegation of abuse made against her. During an interview on 10/16/2024 at 9:00 AM, CNA H said he worked on 09/21/2024. CNA H said Resident #233 kept asking the staff to take her to smoke. CNA H said there were multiple staff at the nurses' station, and another staff (unable to recall who the staff was) told Resident #233 they would take her to smoke. RN N told Resident #233 the staff was doing her a mother fucking favor by taking her out to smoke. CNA H said he had not reported this to the Administrator, the abuse coordinator, because multiple staff heard the comment including RN D (CNA H was unable to recall the other staffs' names). CNA H said he believed RN D would handle the situation. CNA H said if there had not been other staff around, he would have reported it to the Administrator because it was verbal abuse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 9:13 AM, RN D said she was the RN supervisor the weekend that the incident with RN N and Resident #233 occurred. RN D said she had not heard RN N tell Resident #233 the staff was doing her a mother fucking favor by taking her out to smoke, and nobody reported this to her. RN D said if she would have heard this, she would have reported it to the abuse coordinator, the administrator, immediately to protect the residents. During an interview on 10/16/2024 at 9:55 AM, Resident #233 said RN N had told her the nurse is doing you a mother fucking favor to take you to smoke. Resident #233 said it made her feel awful. Resident #233 said she did not want to take RN N's time up she knew she was busy. Resident #233 said she was scared of RN N's attitude because she did not know what she (RN N) was going to do next. During an interview on 10/16/2024 at 10:20 AM, the DON said she did not remember much about the investigation she just remembered that Resident #233 had transferred to a different facility the next day. The DON said she had not reached out to RN N to ask her what happened with Resident #233. The DON said she was not notified about RN N telling Resident #233 the staff was doing her a mother fucking favor by taking her out to smoke. The DON said that should have been reported, and RN N should have been sent home to ensure the residents were safe and did not have any emotional distress. The DON said the facility did a lot of training on abuse upon hire and the facility provided frequent in-services on abuse. The DON said for staff that was employed through an agency the agency did their abuse training and checked their backgrounds. The DON said they tried to in-service the agency staff when they gave in-services about abuse and agency staff were present in the facility at the time of the in-service. The DON said she was not sure if RN N had received any abuse training by the facility. During an interview on 10/16/2024 at 10:54 AM, the Administrator said he was not notified by CNA H or any of the staff who worked on 09/21/2024 of RN N telling Resident #233 the nurse was doing her a mother fucking favor by taking her out to smoke. The Administrator said he should have been notified immediately of the incident. The Administrator said they were continually monitoring for abuse and neglect daily and in-serviced the facility staff frequently on abuse and neglect. The Administrator said they also performed angel rounds where the department heads had room assignments and every morning they checked on the residents. The Administrator said safe surveys were completed on residents who were able to be interviewed when incidents that were reportable occurred. The Administrator said the abuse training for agency staff was completed by the staffing agency. The Regional Compliance Nurse was with the Administrator during the interview, and she said that when agency staff went to the facility to work there was a training packet the facility should have them complete. The training packet was specifically for agency staff, and it contained abuse training for them. The Regional Compliance Nurse said she did not know if the facility had completed this for RN N. The Administrator said he had reached out to the staffing agency RN N was employed by to get her abuse training, and he would check with human resourced to see if RN N had completed the packet. During an interview on 10/16/2024 at 4:13 PM, the Administrator said the staffing agency had not sent him RN N's abuse training yet, and he did not have any abuse training RN N had completed at the facility. Abuse training from the staffing agency for RN N was not received upon exit of the facility. During an interview on 10/17/2024 at 12:55 PM, the Administrator said he expected for all the staff to be properly trained on abuse and neglect. The Administrator said human resources was doing the abuse and neglect training. The Administrator said it was important for the staff to complete abuse and neglect training to prevent abuse and neglect to the residents. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health and Wellness	110 N State Hwy 274 Kemp, TX 75143

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 1:26 PM, Human Resources said she completed abuse training during orientation. Human Resources said she did not do anything with agency staff. Human Resources said the Staffing Coordinator completed a check off list with them, and the Staffing Coordinator kept up with it. Human Resources said it was important for abuse and neglect training to be completed so the residents were not abused and neglected, and this was the residents' home and if the staff see abuse or neglect, they needed to intervene appropriately. During an interview on 10/17/2024 at 1:35 PM, the Staffing Coordinator said prior to this week they did not have anything in place for the abuse and neglect training for agency staff. The Staffing Coordinator said sometimes agency staff would sign abuse and neglect in-services. The Staffing Coordinator said she did not have any abuse trainings for RN N. The Staffing Coordinator said it was important for the staff to complete abuse and neglect trainings so none of the residents were abused or neglected. Record review of the facility's Resident Abuse and Neglect Policy 2021, indicated, . Our Facility will not condone resident abuse by anyone, including associates {associates herein refer to covered individuals), staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. 2. Employee/Associates, consultants, and attending physicians shall report any suspected abuse or incidents of abuse to the community designated abuse coordinator promptly. In the absence of the Facility Abuse Coordinator, such reports may be made to the Director of Nursing Services and if not available then to the nurse supervisor on duty. In accordance with S.B. 9 failure to report, abuse is a misdemeanor. 3.The Administrator and Director of Nursing Services shall be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services shall be called at home or shall be paged and informed of such incident .c) Verbal abuse: may be considered to be a type of mental abuse. Verbal abuse is defined as any oral, written, or gestured communication or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. It is language that includes disparaging or derogatory terms to a resident or within their hearing distance, regardless of the resident's age, ability to comprehend., or disability . All new and existing team members receive periodic in-service training relative to resident rights and our Facility's abuse prevention program policies and procedures 1. Associates are required to attend our Facility's resident rights and abuse prevention program and dementia management (communication & caring for the cognitively Impaired) in-service training sessions before having any resident contact .

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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** 46892 Based on interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, for 1 of 23 residents (Resident #233) reviewed for abuse reporting. The facility failed to ensure CNA H immediately reported RN N's verbal abuse towards Resident #233 on 09/21/2024 to the abuse coordinator or designee. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of a face sheet dated 10/17/2024 indicated Resident #233 was a [AGE] year-old female admitted to the facility on [DATE] and discharged [DATE] with diagnoses which included displaced spiral fracture of shaft of right tibia (right fracture of the shin bone). Record review of the 5-day MDS assessment dated [DATE] indicated Resident #233 was able to understand others and was understood by others. The MDS assessment indicated Resident #233 had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #233 required partial/moderate assistance with toileting, showering, and lower body dressing and supervision/touching assistance for upper body dressing and oral hygiene and was independent for eating. Record review of Resident #233's care plan with date initiated 09/20/2024 indicated she used anti-anxiety medications related to an anxiety disorder to monitor her every shift and as needed for safety. During an interview on 10/15/2024 at 3:09 PM, RN N said she was not an employee of the facility that she was employed through a staffing agency. RN N said she had never had any incidents with anybody at the facility. RN N said she did not know who Resident #233 was. RN N said she had never had any allegations of abuses against her, and she would never abuse or cuss at a resident. RN N said she had not been contacted by the facility regarding the allegation of abuse made against her. During an interview on 10/16/2024 at 9:00 AM, CNA H said he worked on 09/21/2024. CNA H said Resident #233 kept asking the staff to take her to smoke. CNA H said there were multiple staff at the nurses' station, and another staff (unable to recall who the staff was) told Resident #233 they would take her to smoke. RN N told Resident #233 the staff was doing her a mother fucking favor by taking her out to smoke. CNA H said he had not reported this to the Administrator, the abuse coordinator, because multiple staff heard the comment including RN D (CNA H was unable to recall the other staffs' names). CNA H said he believed RN D would handle the situation. CNA H said if there had not been other staff around, he would have reported it to the Administrator because it was verbal abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 9:13 AM, RN D said she was the RN supervisor the weekend that the incident with RN N and Resident #233 occurred. RN D said she had not heard RN N tell Resident #233 the staff was doing her a mother fucking favor by taking her out to smoke, and nobody reported this to her. RN D said if she would have heard this, she would have reported it to the abuse coordinator, the administrator, immediately to protect the residents. During an interview on 10/16/2024 at 9:55 AM, Resident #233 said RN N had told her the nurse is doing you a mother fucking favor to take you to smoke. Resident #233 said it made her feel awful. Resident #233 said she did not want to take RN N's time up she knew she was busy. Resident #233 said she was scared of RN N's attitude because she did not know what she (RN N) was going to do next. During an interview on 10/16/2024 at 10:20 AM, the DON said she did not remember much about the investigation she just remembered that Resident #233 had transferred to a different facility the next day. The DON said she had not reached out to RN N to ask her what happened with Resident #233. The DON said she was not notified about RN N telling Resident #233 the staff was doing her a mother fucking favor by taking her out to smoke. The DON said that should have been reported, and RN N should have been sent home to ensure the residents were safe and did not have any emotional distress. The DON said the facility did a lot of training on abuse upon hire and the facility provided frequent in-services on abuse. During an interview on 10/16/2024 at 10:54 AM, the Administrator said he was not notified by CNA H or any of the staff who worked on 09/21/2024 of RN N telling Resident #233 the nurse was doing her a mother fucking favor by taking her out to smoke. The Administrator said he should have been notified immediately of the incident. The Administrator said they were continually monitoring for abuse and neglect daily and in-serviced the facility staff frequently on abuse and neglect. The Administrator said they also performed angel rounds where the department heads had room assignments and every morning they checked on the residents. The Administrator said safe surveys were completed on residents who were able to be interviewed when incidents that were reportable occurred. Record review of the facility's Resident Abuse and Neglect Policy 2021, indicated, . Our Facility will not condone resident abuse by anyone, including associates {associates herein refer to covered individuals), staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. 2. Employee/Associates, consultants, and attending physicians shall report any suspected abuse or incidents of abuse to the community designated abuse coordinator promptly. In the absence of the Facility Abuse Coordinator, such reports may be made to the Director of Nursing Services and if not available then to the nurse supervisor on duty. In accordance with S.B. 9 failure to report, abuse is a misdemeanor. 3.The Administrator and Director of Nursing Services shall be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services shall be called at home or shall be paged and informed of such incident .c) Verbal abuse: may be considered to be a type of mental abuse. Verbal abuse is defined as any oral, written, or gestured communication or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. It is language that includes disparaging or derogatory terms to a resident or within their hearing distance, regardless of the resident's age, ability to comprehend., or disability .

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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** 47006 Based on interviews and record review the facility failed to develop and implement the baseline care plan that included the minimum healthcare information necessary to properly care for a resident including, but not limited to - initial goals based on admission orders and physician orders for 1 of 4 (Resident #225) residents reviewed for baseline care plans. The facility did not ensure Resident #225's preferred code status was addressed on the baseline care plan. This failure could affect residents by not addressing their physical, mental, and psychosocial needs for each resident to attain or maintain their highest practicable physical, mental, and psychosocial outcome. The findings included: Record review of the face sheet, dated 10/16/2024, revealed Resident #225 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors), schizoaffective disorder, bipolar type (a mental illness that is generally characterized by a combination of schizophrenic and mood disorder symptoms), traumatic brain injury (brain injury that is caused by an outside force), and heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of the entry MDS assessment, dated 10/10/2024, revealed Resident #225 recently admitted to the facility on [DATE] from an in-patient psychiatric facility. Record review of Resident #225's baseline care plan, dated 10/10/2024, did not address her preferred code status or advanced directive. During an interview on 10/17/2024 beginning at 9:45 AM, the Social Worker stated a code status assessment was one of the first things completed on a resident who admitted to the facility. The Social Worker stated a code status assessment was completed on Resident #225, which indicated she requested a full code status at the facility. The Social Worker stated she did not enter the code status onto the baseline care plan. The Social Worker stated the MDS Coordinator or nursing staff were responsible for completing the baseline care plan. During an interview on 10/17/2024 beginning at 1:16 PM, the MDS Coordinator stated the baseline care plan was completed as an IDT. The MDS Coordinator stated she was responsible for ensuring the baseline care plan was completed as she signed off on it. The MDS Coordinator stated the code status section on the baseline care plan auto populated from the face sheet. The MDS Coordinator stated she probably opened the baseline care plan assessment before the code status was filled out, so it did not auto populate. The MDS Coordinator stated she did not feel like it was important for the code status to have been included in the baseline care plan because the IDT discussed Resident #225's code status verbally. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 beginning at 1:31 PM, the Corporate Regional Nurse stated the facility followed the Texas Administrative Code regarding baseline care plans. The Regional Nurse stated the facility did not have a policy specific to baseline care plans. During an interview on 10/17/2024 beginning at 1:37 PM, the DON and Administrator were interviewed together. The DON and Administrator stated the code status should have been included on the baseline care plan. The Administrator stated new admissions were reviewed in the daily clinical meeting. The Administrator stated the staff should have caught the error. The Administrator stated it was important to ensure the code staff was included in the baseline care plan to respect the resident's wishes. Record review of the Texas Administrative Code, Title 26, Part I, Chapter 554, Subchapter 1 revealed the facility must 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 care. The baseline care plan must: .include the minimum healthcare information necessary to properly care for a resident, included: initial goals based on admission orders; physician orders .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observations, interviews, and record review the facility failed to ensure necessary services to maintain grooming and personal hygiene were provided for 1 of 4 residents reviewed for ADLs. (Resident #224) The facility failed to ensure Resident #224 was assisted with facial hair removal. These failures could place residents at risk of not receiving care or services, decreased quality of life, embarrassment, and decreased self-esteem. The findings included: Record review of the face sheet, dated 10/17/2024, revealed Resident #224 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of unspecified dementia without behaviors (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). The face sheet further revealed Resident #224 was receiving hospice services. Record review of the admission MDS assessment, dated 10/09/2024, revealed Resident #224 had clear speech and was understood by others. The MDS revealed Resident #224 was able to understand others. The MDS revealed Resident #224 had a BIMS score of 3, which indicated severe cognitive impairment. The MDS revealed Resident #224 had no behaviors or refusal of care. The MDS revealed Resident #224 required partial/moderate assistance (helper does less than half the effort) with personal hygiene. The MDS revealed Resident #224 was receiving hospice services in the facility. Record review of the comprehensive care plan, initiated 10/15/2024, revealed Resident #224 had an ADL self-care performance deficit related to dementia. The interventions included: Ensure/promote resident self esteem and dignity while performing ADL care and Personal Hygiene: the resident requires 1 staff assist with personal hygiene and oral care. The comprehensive care plan further revealed Resident #224 was receiving hospice services. The interventions included: Adjust provision of ADLs to compensate for resident's changing abilities. Record review of the ADL task documentation for personal hygiene, dated 10/04/2024 to 10/16/2024 revealed Resident #224 required limited to extensive assistance. During an observation and interview on 10/14/2024 beginning at 11:38 AM, Resident #224 was laying in the bed with the head of her bed elevated slightly. Resident #224's had approximately 1-inch black and gray facial hairs to the sides of her mouth. Resident #224's eyes became wide, and she placed her hands up to cover her mouth when the surveyor asked if the staff assisted her with facial hair removal. Resident #224 stated the staff had not offered to help her remove it and she was unaware she had facial hair. Resident #224 stated she wanted help from the staff with removing her facial hair. Resident #224 stated she was embarrassed to have facial hair. During an observation on 10/15/2024 beginning at 10:43 AM, Resident #224 had approximately 1-inch black and gray facial hairs to the sides of her mouth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 beginning at 12:27 PM, Hospice CNA B stated she provided care for Resident #224 at the facility. Hospice CNA B stated she gave Resident #224 her baths and helped her make her bed. Hospice CNA B stated she only provided care to Resident #224 at the facility three times a week. Hospice CNA B stated the facility staff were responsible for providing care to Resident #224 when she did not come. Hospice CNA B stated she had not offered or asked Resident #224 if she wanted help removing her facial hairs. Hospice CNA B stated she had not noticed Resident #224's facial hairs. Hospice CNA B stated facial hair removal was not on the plan of care for the hospice, but it was something she could have assisted her with. Hospice CNA B stated it was important to ensure Resident #224 was assisted with facial hair removal because a woman wouldn't want facial hair. During an interview on 10/17/2024 beginning at 12:33 PM, LVN A stated the hospice CNAs did come to the facility and perform care for Resident #224. LVN A stated the facility staff also performed ADL care for Resident #224. LVN A stated facial hair removal is usually completed with bathing. LVN A stated if facility staff noticed facial hair, they should have asked if Resident #224 wanted help removing it. LVN A stated it was important to assist Resident #224 with facial hair removal to maintain her dignity. During an interview on 10/17/2024 beginning at 1:09 PM, CNA C stated she assisted females with facial hair removal if they asked her. CNA C stated she had not assisted Resident #224 with facial hair removal. CNA C stated she had not asked if she needed assistance. CNA C stated it was important to assist Resident #224 with facial hair removal to respect her rights and maintain her dignity. During an interview on 10/17/2024 beginning at 1:37 PM, the DON and Administrator were interviewed together. The DON stated she expected facial hair to be removed if the resident's asked. The DON stated CNA's and nurses were responsible for ensuring facial hair was removed. The Administrator stated the facility staff performed angel rounds daily, however, they were not trained specifically to look for facial hair. The DON stated if the facial hair was noticed they should have asked the resident if she wanted assistance with removing it. The Administrator stated it was important to ensure facial hair removal was offered to maintain her dignity. Record review of the Certified Nurse Aide Standards of Clinical Practice policy, updated 03/12/2019, revealed the CNA assists the resident in activities of daily living such as .bathing, grooming . Record review of the Activities of Daily Living (ADL), Supporting policy, revised March 2018, revealed appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene

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F 0690 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review the facility failed to ensure a resident who was incontinent of the bladder and had an indwelling urinary catheter received appropriate treatment and services for 1 of 3 residents (Resident 30) reviewed for urinary catheters. The facility failed to properly anchor Resident #30's foley catheter to prevent pulling and tension of the foley catheter tubing which resulted in a tear in his penis 3.5 cm in length and an ER visit on [DATE]. This failure could place residents at risk of injury, urinary tract infections, and a decreased quality of life. Findings included: Record review of a face sheet dated [DATE] indicated Resident #30 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system), dementia (memory loss), benign prostatic hyperplasia (enlarged prostate blocks the flow of urine), and retention of urine. Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #30 was able to make himself understood and understood others. The MDS assessment indicated Resident #30 had a BIMS score of 13, which indicated his cognition was intact. The MDS assessment indicated Resident #30 required substantial/maximal assistance with eating, toileting hygiene, dressing, and partial/moderate assistance with personal hygiene. The MDS assessment indicated Resident #30 had an indwelling catheter. Record review of Resident #30's care plan with a date initiated of [DATE] indicated he had an ADL self-care performance deficit related to dementia, hemiplegia (paralysis or weakness of one side of the body), limited mobility, and stroke and required assistance of one staff for bathing, bed mobility, dressing and personal hygiene. Resident #30's care plan indicated he had an indwelling catheter related to benign prostatic hyperplasia to check the tubing for kinks each shift, monitor for signs and symptoms of discomfort on urination and frequency, monitor/document for pain/discomfort due to catheter, monitor/record/report to doctor for signs and symptoms of urinary tract infection, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Record review of Resident #30's Order Summary Report dated [DATE] indicated: foley catheter care every shift and as needed with a start date of [DATE] secure catheter with leg strap with a start date of [DATE] (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Some	urinary catheter with a start date of [DATE]. Record review of Resident #30's Clinical Admission completed [DATE] indicated he had a foley catheter and his skin was within the normal limits. Resident #30's Clinical Admission did not indicate any tears in his penis. Record review of Resident #30's Weekly Skin Observation completed on [DATE] and [DATE] by RN F did not indicate tears in his penis or any penile issues. Record review of Resident #30's progress notes indicated: [DATE] at 9:05 PM Responsible Party in facility to see resident earlier on tonight. Requested said nurse to assess his father. Resident noted /c (with) malodor to the groin area. His ureter was noted torn measuring 3. 5cm in length (from tip of penis to shaft of penis). Foley catheter in place. Redness also noted to scrotum and inner right leg. No bleeding noted. Denies pain. No shock symptoms noted. Tear not noted fresh. Requested that [NAME] be called, which took place via conference call will both Rp/D.O.N. Resident with request of family member was sent out via ambulance to hospital. Message left via answering service for PCP regarding findings and transfer to hospital. Signed by Charge Nurse G. [DATE] at 1:32 AM Patient arrived back in facility from ER via transportation from family. Patient is stable with no complaints of any pain and is resting comfortably back in bed with call [sic] within reach. Patients family is very admit [sic] about making sure patient is changed frequently and peri care performed regularly. Patient came back with new orders from ER with Cephalexin (antibiotic) 50mg po BID for 7 days, Bacitracin (antibiotic ointment) BID to penis for 7 days, Clotrimazole antifungal cream to groin, referral for urologist for suprapubic catheter (tube that drains urine from the bladder from a small incision in the abdomen) consult. Signed by Charge Nurse Y. Record review of Resident #30's ER After Visit Summary dated [DATE] indicated reason for visit penis injury and hand injury and diagnoses of erosion of penis (breakdown of tissue at the catheter insertion site), sebaceous cyst (fluid filled lump under the skin) and tinea cruris (fungal skin infection). During an interview on [DATE] at 10:45 AM, Resident #30's family member was at his bedside. Resident #30's family member said approximately five months ago they had visited Resident #30 and noticed a bad odor. Resident #30's family member said upon inspection of Resident #30's penis and foley catheter they realized the odor was coming from his private area. Resident #30's family member said there was blood and they noticed he had a split penis. Resident #30's family member said the facility had not been providing Resident #30 foley catheter care like they were supposed to. Resident #30's family member said they spoke with the DON regarding the lack of care being provided to Resident #30 and that same night ([DATE]) Resident #30 was sent to the ER for evaluation. (continued on next page)

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Lakeside Health and Wellness	110 N State Hwy 274 Kemp, TX 75143

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F 0690 Level of Harm - Actual harm Residents Affected - Some	During an interview on [DATE] at 5:01 PM, RN F said he had provided care to Resident #30. RN F said when Resident #30 admitted to the facility he had not seen any issues with his foley catheter or penis. RN F said he remembered the incident when Resident #30 was sent to the ER for evaluation for his split penis. RN F said he remembered Resident #30's family member brought it up to the facility staff. RN F said prior to Resident #30's family member identifying the penile erosion he had performed assessments on Resident #30 and there were no issues with his penis or catheter. RN F said if a resident had penile erosion upon admission to the facility it should be documented on the skin assessments. During an attempted phone interview on [DATE] at 5:12 PM, Charge Nurse G did not answer the phone. During an attempted observation and an interview on [DATE] at 5:29 PM, Resident #30's family members were at bedside and informed the surveyor Resident #30 was deceased and they preferred not to be bothered. During an interview on [DATE] at 12:30 PM, the DON said Resident #30's family member contacted her and sent her a picture of Resident #30's penis. The DON said she called Resident #30's family member to address the situation and ensure the resident was okay. The DON said she instructed the staff to send Resident #30 to the ER for evaluation. The DON said she believed Resident #30 admitted to the facility with the penis erosion. The DON said she could not find documentation of it in Resident #30's electronic medical record. The DON said she would continue to search through Resident #30's assessments to see if it was documented (documentation that Resident #30 admitted to the facility with the penis erosion was not provided upon exit of the facility). The DON said she told Resident #30's family member the injury to his penis was probably due to the catheter strap that was securing his foley catheter was on him too tight. The DON said the staff were not giving foley catheter enough slack for when he sat up or got up to walk with therapy. The DON said the foley catheter not having enough slack was causing friction and pulling the foley catheter. The DON said the CNAs and the nurses should be ensuring residents with a foley catheter have it properly secured and that it has enough slack so it will not get pulled and to prevent injury. The DON said she believed after the incident she had done an in-service with the staff, but she was not sure. The DON said she remembered doing verbal teaching with the staff regarding Resident #30's foley catheter and ensuring it was not getting pulled. During a phone interview on [DATE] at 1:59 PM, the DON brought her cell phone to the surveyor and Resident #30's family member was on the phone. Resident #30's family member said when he noticed Resident #30's penile erosion he had freaked out because it was a traumatic thing. Resident #30's family member said a week later Resident #30 was taken to the urology clinic, and it was explained to him that penile erosion was a common thing for long-term catheter use. Resident #30's family member said upon admission to the facility Resident #30 did not have any physical signs of penile erosion. During an interview on [DATE] at 1:31 PM, the facility's policy regarding foley catheter care was requested from the Regional Compliance Nurse and not received upon exit of the facility. Record review of the CDC's Indwelling Urinary Catheter Insertion and Maintenance accessed on [DATE] indicated, .Properly secure catheters to prevent movement and urethral traction .Catheter securement devices act as an anchor to prevent tugging and pulling which can cause irritation and inflammation. When catheters are not secured in male patients, the tugging and pulling can cause pressure sores on the penis tip .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for the facility's only resident with an enteral device (Resident #57). The facility failed to ensure LVN W checked Resident #57's gastrostomy placement (placement of the tube used for nutrition and medication administration) as ordered by the physician on 10/15/24. This failure could affect residents receiving enteral nutrition and hydration by placing them at risk of health complications. Findings included: Record review of Resident #57's face sheet dated 10/17/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), essential hypertension (high blood pressure), congestive heart failure (heart does not pump blood as well as it should), gastrostomy status (surgical opening into the stomach for nutritional support and medication administration), and dysphagia (difficulty swallowing). Record review of Resident #57's quarterly MDS assessment dated [DATE], indicated Resident #57 was rarely/never understood and usually understood others. The MDS assessment indicated Resident #57 had short term and long-term memory problems. The MDS assessment indicated Resident #57 was dependent on staff with eating, oral hygiene, toileting, personal hygiene, and showers. The MDS assessment indicated Resident #57 had a feeding tube. Record review of Resident #57's comprehensive care plan dated 03/28/24, indicated Resident #57 required tube feeding related to dysphagia and swallowing problems. The care plan interventions indicated to check for tube placement and gastric contents/residual volume per facility protocol and record, resident needs total assistance with tube feeding and water flushes. Record review of Resident #57's order summary report dated 10/17/24, indicated he had the following orders: *Nothing by mouth (NPO) diet with an order start date of 05/22/24. *Confirm g-tube placement via auscultation of 10 mls of air. Hold if placement cannot be confirmed and notify MD/NP every 4 hours for enteral feeding with an order start date of 05/22/24. *Check gastric residual volume (GRV) every 4 hours and hold feeding if residuals are greater than 500mls. Return GRV to stomach and recheck in 4 hours. If enteral feedings were held for high GRV for 3 consecutive checks, notify the physician or NP for additional orders with an order start date of 06/14/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Do not cocktail medications with an order start date of 05/22/24. During an observation and interview on 10/15/24 at 11:20 AM, LVN W prepared Resident #57's morning medications by crushing all medications together. LVN W applied PPE and entered Resident #57's room to attempt to administer his medications. LVN W applied the syringe to Resident #57s gastrostomy tube and checked Resident #57's residual by pulling back on the syringe with no residual noted. LVN W did not confirm placement via auscultation as ordered by the physician. Surveyor intervened before medications were administered. LVN W said she did not remember if she could cocktail Resident #57's medications but that was what she had been doing. LVN W said she had not checked placement by auscultation as ordered because she had done it that morning. LVN W said she was responsible for ensuring medications were being administered as ordered by the physician. LVN W said by cocktailing medications Resident #57 was at risk for an adverse reaction. LVN W said by not checking placement as ordered, Resident #57 was at risk for his gastrostomy tube to be out of place. LVN W said she had been checked off on medication administration via the gastrostomy tube. During an interview on 10/16/24 at 4:28 PM, the DON said she did not have a medication administration via the gastrostomy tube competency skills check off for LVN W. During an interview on 10/17/24 at 11:32 AM, the DON said when peg tube medications were being administered, peg tube placement should be checked via auscultation and residual. The DON said medications should not be cocktailed because it could cause harm or cause a change in condition to the resident. The DON said medications should be crushed individually. The DON said LVN W was responsible for ensuring medications via the gastrostomy tube were administered as ordered by the physician. The DON said by not checking placement as ordered Resident #57's peg tube could be out of place. During an interview on 10/17/24 at 11:36 AM, the Administrator said he expected LVN W to administer medications as per the physician orders. The Administrator said the nurses should follow best practice and what they have been trained to do. The Administrator said by not administering medications as ordered there was a potential for harm or change in condition. The Administrator said the licensed individual administering the medications was responsible for ensuring the mediations were administered as ordered. Record review of the facility's policy Administering Medications through an Enteral Tube revised November 2018, indicated . The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Preparation.1. Verify that there is a physician's medication order for this procedure . Follow the medication administration guidelines in policy entitled Administering Medications . 3. Administer each medication separately and flush between medications . Steps in the procedure . 3. Prepare the medication: a. check the label and confirm the medication name and dose with the MAR . 6. Verify placement of feeding tube . 9. Dilute medication: a remove plunger from syringe. Add medication and appropriate amount of water to dilute. b. dilute crushed (powdered) medication with at least 30mls of purified water (or prescribed amount) . 10. Administer each medication separately . 12. Administer medication by gravity flow . 13. If administering more than one mediation, flush with 15mls warm water (or prescribed amount) between medications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observations, interviews, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 2 of 3 residents (Residents #43 and Resident #56) reviewed for respiratory care. 1. The facility failed to ensure Resident #56's oxygen concentrator was set at 2 liters per nasal cannula as ordered by the physician. 2. The facility failed to ensure Resident #43's oxygen concentrator was clean. These failures could place residents requiring respiratory care at risk for shortness of breath, respiratory distress, or complications. Findings included: 1. Record review of a face sheet dated 10/17/2024 indicated Resident #56 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #56 was usually able to understand others and was usually understood by others. The MDS assessment indicated Resident #56 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #56 required partial/moderate assistance for dressing, toileting and personal hygiene, substantial/maximal assistance with bathing. The MDS assessment indicated Resident #56 received oxygen therapy while a resident at the facility. Record review of Resident #56's care plan date initiated 08/30/2024 indicated she had chronic obstructive pulmonary disease with oxygen settings for oxygen via nasal cannula at 2-4 liters per minute continuously. Record review of Resident #56's Order Summary Report dated 10/17/2024 indicated oxygen at 2 liters per minute via nasal cannula every shift related to chronic obstructive pulmonary disease with a start date of 08/30/2024. During an observation on 10/14/2024 at 11:30 AM, Resident #56 was lying in bed wearing her oxygen via nasal cannula. Resident #56's oxygen was set between 3-4 liters per minute. During an observation and interview on 10/17/2024 at 10:50 AM, LVN A checked the settings on Resident #56's oxygen. LVN A said Resident #56's oxygen was set at 3 liters per minute and her order was for 2 liters per minute. LVN A said it was the nurse's responsibility to ensure the residents oxygen was set as ordered by the physician. LVN A said it was important for the oxygen to be set as ordered by the physician to follow the doctor's order and because a resident could get too much or not enough oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of a face sheet dated 10/15/2024 indicated Resident #43 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (right sided weakness and paralysis after unspecified disease affecting the brain) and chronic respiratory failure (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #43 was able to make herself understood and understood others. The MDS assessment indicated Resident #43 had a BIMS score of 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #43 required partial/moderate assistance for toileting, bathing, and personal hygiene. The MDS assessment indicated Resident #43 received oxygen therapy while a resident at the facility. Record review of Resident #43's Order Summary Report dated 10/17/2024 indicated, oxygen at 2-4 liters per minute via nasal canula as needed for shortness of breath with a start day of 08/19/2024. Resident #43's orders did not indicate cleaning the oxygen concentrator. Record review of Resident #43's care plan date initiated 07/06/2024 indicated the resident has the potential for shortness of breath oxygen therapy per the doctor's orders. During an observation and interview on 10/14/2024 at 11:55 AM, Resident #43 was lying in bed wearing oxygen via nasal cannula. Resident #43's oxygen concentrator had white speckles on the outside of it with a layer of dust. The dust was layered on the back as well and there was a thick layer of built-up, gray, fuzzy material on the oxygen concentrator vents on the back. Resident #43 said the nurse changed out the humidifier and tubing, but she was not sure if they were cleaning the oxygen concentrator. During an interview on 10/16/2024 at 3:23 AM, RN D said she provided care to Resident #43. RN D said she had changed the water on Resident #43's oxygen concentrator, but she had not noticed it was dirty. RN D said she believed the Staffing Coordinator was responsible for cleaning the oxygen concentrators. RN D said it was important for the oxygen concentrators to be cleaned because the air was going to the residents' lungs, and they could get infections. During an interview on 10/16/2024 at 3:35 PM, the Staffing Coordinator said she was not responsible for cleaning the oxygen concentrators. The Staffing Coordinator said housekeeping, CNAs or the nurses should be cleaning the oxygen concentrators in the residents' rooms. During an interview on 10/17/2024 at 11:58 AM, the DON said anyone could wipe down an oxygen concentrator. The DON said angel rounds were completed daily to check the room and their cleanliness. The DON said the nurses should be checking the settings on the oxygen at least every shift. The DON said if they noticed the oxygen was not set per the doctor's order, they should correct the situation and ensure the resident was safe, assess the resident and notify the doctor. The DON said it was important for the oxygen to be set per the doctor's order because it could cage a respiratory change of condition and it could cause harm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 12:09 PM, the Administrator said the charge nurses should be checking the resident's oxygen settings because it could be too high or too low for them. The Administrator said it was important for the oxygen concentrators to be cleaned for a pleasant living environment free of dust and debris. The Administrator said the cleanliness of the concentrators should be checked on room rounds by the department heads. Record review of the undated facility's policy titled, Oxygen Administration, indicated, Purpose: A resident will receive oxygen therapy when ordered by a physician . 3. Obtain physician orders for oxygen administration. Orders should include the following: a. oxygen source to be used (concentrator, tank, etc.) b. method of delivery (cannula, mask, etc.) c. flow rate of delivery d. oxygen saturation monitoring parameters, if indicated . The policy did not address cleaning of the oxygen concentrator.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 3 of 3 residents (Resident #8, Resident #22, and Resident #15) reviewed for pharmacy services. The facility failed to ensure MA V accurately reconciled Resident #8's narcotic medication log when she administered Resident #8's morphine (controlled medication used for pain) tablet on 10/15/24. The facility failed to ensure MA V accurately reconciled Resident #22's narcotic medication log when she administered Resident 22's pregabalin (controlled medication used to treat pain caused by nerve damage) tablet on 10/15/24. The facility failed to ensure LVN W accurately reconciled Resident #15's narcotic medication log when she administered Resident #15's Norco (controlled medication used for pain) tablet on 10/15/24. These failures could place residents at risk for loss of prescribed medications, resident's safety, and drug diversion. Findings included: 1. Record review of Resident #8's face sheet dated 10/17/24, indicated Resident #8 admitted to the facility on [DATE] with diagnoses which included dementia (memory loss), depression (persistent feeling of sadness and loss of interest), essential hypertension (high blood pressure), sciatica (pain radiating along the sciatic nerve, which runs down one or both legs from the lower back), and chronic obstructive pulmonary disease (a chronic lung disease that limits airflow and causes ongoing respiratory symptoms). Record review of Resident #8's admission MDS assessment dated [DATE], indicated Resident #8 was able to make herself understood and usually understood others. The MDS assessment indicated Resident #8 had a BIMS score of 11, indicating her cognition was moderately impaired. The MDS assessment indicated Resident #8 received scheduled pain medication and had received an opioid (narcotic) medication within the 7-day look back period. Record review of Resident #8's comprehensive care plan revised on 09/10/24, indicated Resident #8 had the potential for pain related to sciatica left side and history of angina pectoris (chest pain). The care plan interventions to anticipate the resident's need for pain relief and respond immediately to any complaints of pain. Record review of Resident #8's order summary report dated 10/17/24, indicated she had an order for Morphine Sulfate ER 15mg give one tablet by mouth two times a day for pain with an order start date of 08/20/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's medication administration record for 10/01/24-10/31/24, indicated Resident #8 received morphine sulfate 15mg twice a day. During an observation on 10/15/24 at 09:01 AM, MA V prepared Resident #8's morning medications. MA V opened the narcotic box located on the medication cart and removed one tablet of morphine 15mg from the medication card and added it to the rest of Resident #8's morning medications. MA V proceeded to administer Resident #8's medications. MA V failed to document the administration of the morphine tablet on Resident #8's narcotic record. 2. Record review of Resident #22's face sheet date 10/17/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included left femur fracture, bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (persistent feeling of sadness and loss of interest), fibromyalgia (long-term condition that involves widespread body pain and tiredness), and osteoarthritis (occurs when flexible tissue at the ends of the bones wears down). Record review of Resident #22's admission MDS assessment dated [DATE], indicate Resident #22 was able to make herself understood and understood others. The MDS assessment indicated Resident #22 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #22 received scheduled pain medication. Record review of Resident #22's comprehensive care plan revised 10/08/24, indicated Resident #22 had a potential for pain related to fibromyalgia, left femur fracture, osteoarthritis of bilateral knees, and chronic pain syndrome. The care plan interventions included to anticipate the residents need for pain relief and respond immediately to any complaint of pain. Record review of Resident #22's order summary report dated 10/17/24, indicated Resident #22 had an order for pregabalin 100mg give one capsule by mouth three times a day for pain with a start date of 09/21/24. Record review of Resident #22's medication administration record dated 10/01/24-10/31/24, indicated Resident #22 received pregabalin morning, midday and at bedtime. During an observation on 10/15/24 at 09:36 AM, MA V prepared Resident #22's morning medications. MA V opened the narcotic box located on the medication cart and removed one tablet of pregabalin 100mg from the medication card and added it to the rest of Resident #22's morning medications. MA V proceeded to administer Resident #22's medications. MA V failed to document the administration of the pregabalin tablet on Resident #22's narcotic record. During an interview on 10/15/24 at 3:30 PM, MA V said she was responsible for documenting on the resident's narcotic record when a narcotic medication was administered but had not since the surveyor was observing the medication pass. MA V said was going to sign off when she completed the medication pass with the surveyor. MA V said not documenting the narcotic medication was administered could cause a discrepancy or a medication error, since someone will not know the resident had already received the narcotic medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #15's face sheet dated 10/17/24, indicated an [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (a chronic lung disease that limits airflow and causes ongoing respiratory symptoms), malignant neoplasm of prostate (prostate cancer), and dementia (memory loss). Record review of Resident #15's quarterly MDS assessment dated [DATE], indicated Resident #15 was able to make himself understood and usually understood others. The MDS assessment Resident #14 had a BIMS score of 14, indicating his cognition was intact. The MDS assessment indicated Resident #15 received scheduled pain medication and PRN pain medications during the 5-day look back period. Record review of Resident #15's comprehensive care plan dated 05/17/24, indicated Resident #15 had the potential for pain related to fracture of right humerus (upper arm fracture) and diabetic neuropathy (nerve damage that occurs with diabetes. The care plan interventions indicted to evaluate the effectiveness of pain interventions. Record review of Resident #15's nursing medication administrator record for 10/01/24-10/31/24, indicated Resident #15 had an order for Norco 10-325mg tablet give one tablet every 6 hours as needed for pain with a start date of 07/24/25. During an observation and interview on 10/15/24 at 3:38 PM, this surveyor performed a random controlled drug count with LVN W of the 300-400 hall nurses' cart. During the drug count LVN W said Resident #15 had 16 tablets of Norco 10/325 mg remaining in the medication card. Surveyor observed 15 tablets of Norco 10/325mg remaining in the medication card. LVN W said she had administered Resident #15 a Norco tablet before lunch. LVN W said she should have signed off on the narcotic record when she administered the Norco tablet to Resident #15, but she was busy with other residents and did not. LVN W said not documenting the Norco being administered to Resident #15 placed Resident #15 at risk for his medication count to be off and could cause a medication error since someone else would not have known he had already received the medication. LVN W said the nurse that administered the narcotic medication was responsible for ensuring the appropriate documentation was completed when administering a narcotic medication. During an interview on 10/17/24 at 11:42 AM, the DON said she expected when narcotic medications were administered the narcotic record should be signed off as soon as the medication was removed from the medication card to ensure the count remained accurate. The DON said by not signing off on the narcotic record mistakes can happen, drug diversion or a medication error. The DON said the person administering the medications was responsible for documenting when a narcotic medication was administered and removed from the narcotic card. During an interview on 10/17/24 at 11:45 AM, the Administrator said when narcotic medications were administered the narcotic record should be signed off for medication accountability. The Administrator said by not signing off the narcotic record when narcotic medications were administered mistakes could happen. The Administrator said there was a risk for drug diversion and medication error as medications could be given again. The Administrator said the licensed person administering the narcotic medication was responsible for documenting it as administered on the narcotic log. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health and Wellness	110 N State Hwy 274 Kemp, TX 75143

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy Controlled Substances revised April 2019 indicated . 8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift 10. Upon administration a. the nurse administering the medication is responsible for recording: 1. Name of the resident receiving the medication; 2. Name, strength, and dose of medication; 3. Time of administration; 4. Method administration; 5. Quantity of the medication remaining; and 6. Signature of nurse administering medication .

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F 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46928

Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 18.75%, based on 12 errors out of 64 opportunities, which involved 2 of 7 residents (Resident #18 and Resident #57) reviewed for medication administration.

The facility failed to ensure LVN W administered Resident #57's scheduled morning medications as prescribed on 10/15/24.

The facility failed to ensure MA X administered Resident #18's multivitamin with minerals and Reglan as prescribed on 10/15/24.

These failures could place residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders.

Findings included:

1. Record review of Resident #57's face sheet dated 10/17/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), essential hypertension (high blood pressure), congestive heart failure (heart does not pump blood as well as it should), gastrostomy status (surgical opening into the stomach for nutritional support and medication administration), and dysphagia (difficulty swallowing).

Record review of Resident #57's quarterly MDS assessment dated [DATE], indicated Resident #57 was rarely/never understood and usually understood others. The MDS assessment indicated Resident #57 had short term and long-term memory problems. The MDS assessment indicated Resident #57 was dependent on staff with eating, oral hygiene, toileting, personal hygiene, and showers. The MDS assessment indicated Resident #57 had a feeding tube. The MDS assessment indicated Resident #57 received anticoagulant and antiplatelet medications within the 7-day look back period.

Record review of Resident #57's comprehensive care plan revised on 05/17/24, indicated Resident had a cerebral vascular accident affecting mobility, speech and cognition. The care plan interventions included to give medications as ordered by the physician.

Record review of Resident #57's order summary report dated 10/17/24, indicated he had the following orders:

*Nothing by mouth (NPO) diet with an order start date of 05/22/24.

*Do not cocktail medications (do not mix all medications together and administer) with an order start date of 05/22/24.

*Flush tube with 30 mls before and after meds every shift for enteral feedings with an order start date of 05/22/24.

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*May crush or open medications and mix each medication with 5mls of water. Give 5-10 mls water between each medication every shift for enteral administration with a start date of 05/22/24. *Amiodarone 400mg give one tablet via g-tube two times a day for abnormal heart rhythm with an order start date of 05/22/24. *Apixaban 5mg give one tablet via g-tube two times a day for anticoagulant (blood thinner) with an order start date of 05/22/24. *Aspirin 81mg give one tablet via g-tube two times a day for anticoagulant with an order start date of 05/22/24. *Entresto 24-26mg give one tablet via g-tube two times day for chronic heart failure hold if SBP less than 110 or DBP less than 60 with an order start date of 07/25/24. *Lipitor 40mg give one tablet via g-tube one time a day for hyperlipidemia (high cholesterol) with an order start date of 05/23/24. *Metoprolol tartrate 25mg give one tablet via g-tube two times a day for hypertension (high blood pressure) with an order start date of 05/22/24. *Montekulast 10mg give one tablet via g-tube one time a day for asthma with an order start date of 05/23/24. *Multivitamin with minerals give one table via g-tube one time a day for supplement with an order start date of 05/23/24. *Thiamine 100mg give one tablet via g-tube one time a day for supplement with an order start date of 05/23/24, *Vitamin C oral liquid give 500mg via g-tube in the morning for supplement 5mls equal 500mg with an order start date of 06/13/24. Record review of Resident #57's nursing medication administration record for 10/01/24-10/31/24, indicated Resident #57 was scheduled to receive Aspirin 81mg one tablet, Lipitor 40mg one tablet, montelukast 10mg tablet, multiple vitamin with minerals one tablet, thiamine 100mg one tablet, vitamin C 500mg, amiodarone 5 mg tablet, apixaban 5 mg one tablet, entresto 24-25mg one tablet, and metoprolol 25mg one tablet via g-tube. The record indicated to not cocktail Resident #57's medications and to flush tube with 30mls of water before and after medications every shift. The nursing administration record indicated to not cocktail medications every shift. The nursing administration record also indicated may crush or open medications and mix each medication with 5mls of water and to give 5-10mls of water between the administration of each medication every shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of medication administration and an interview on 10/15/24 at 11:05 AM, LVN W obtained Resident #57's following medications: Vitamin C 500mg tablet, multivitamin tablet, thiamin 100mg tablet, aspirin 81 tablet, amiodarone 400mg tablet, metoprolol 25mg tablet, montekulast 10mg tablet, atorvastatin tablet and crushed all medications together in a pill crusher pouch. LVN W said she was not placing the entresto 24-26mg tablet or the Eliquis 5mg tablet until she obtained Resident #57's blood pressure (Eliquis does not require a blood pressure reading for administration). LVN W obtained Resident #57's blood pressure with readings of 87/48 and pulse of 63. LVN W said she was not administering the Entresto tablet or the Eliquis tablet because Resident #57's blood pressure was low. LVN W and LVN Z applied PPE and entered Resident #57's room. LVN W had the pill crusher pouch with the crushed medications inside in her hand. LVN W obtained a 60 mls syringe, attached it to Resident #57's enteral feeding tube, and checked for residual by pulling back on the syringe. No residual noted. LVN W did not confirm placement via auscultation as ordered by the physician. LVN W then used the syringe and obtained over 60mls of water and flushed Resident #57's gastrostomy tube. LVN W then removed the stopper from the syringe, placed her pointer finger on the tip of the syringe, and poured the crushed medications from the pouch into the syringe. LVN W then applied the stopper to the top of the syringe, turned the syringe upside down, then inverted it into a cup with water, and added approximately 50mls of water into the syringe. LVN W then mixed the medications in the syringe by shaking it. LVN W was in the process of applying the syringe with medications to Resident #57's gastrotomy tube to administer them, when surveyor intervened before the medications were administered. LVN W said she did not remember if she could cocktail Resident #57's medications, but that was what she had been doing. LVN W said she had not checked placement by auscultation as ordered because she had done it that morning. LVN W said she should not have crushed Resident #57's metoprolol tablet with his medications since it was a blood pressure medication and Resident #57's blood pressure was low. LVN W said if she had administered the blood pressure medication Resident #57 was at risk for bis blood pressure bottoming out. LVN W said she did not place the Eliquis tablet in Resident #57's medications because she thought it was for his blood pressure. LVN W said failure to administer the Eliquis placed Resident #57 at risk of having a blood clot since Eliquis was a blood thinner. LVN W said she was responsible for ensuring medications were being administered as ordered by the physician. LVN W said by cocktailing medications Resident #57 was at risk for an adverse reaction. LVN W said by not checking placement as ordered, Resident #57 was at risk for his gastrostomy tube to be out of place. LVN W said she had been checked off on medication administration via the gastrostomy tube. LVN Z said the metoprolol, Entresto and amiodarone were the medications that should have been held and all should have had blood pressure parameters. 2. Record review of Resident #18's face sheet dated 10/17/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included dementia (memory loss), gastritis (inflammation of the stomach lining), ulcerative colitis (inflammatory bowel disease that causes inflammation and ulcers in the colon and rectum), gastro-esophageal reflux disease (chronic acid reflux in the esophagus) and protein-calorie malnutrition (not enough protein and calories in diet). Record review of Resident #18's quarterly MDS assessment dated [DATE], indicated Resident #18 was able to make herself understood and understood others. The MDS assessment Resident #18 had a BIMS score of 11, indicating her cognition was moderately impaired. Record review of Resident #18's comprehensive care plan dated 09/03/24, indicated Resident #18 had GERD with the potential for heartburn and reflux. The care plan interventions included to give medications as ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #18's order summary report dated 10/17/24, indicated Resident #18 had the following orders: *Multiple vitamin-minerals give one tablet by mouth one time a day for supplement with an order start date of 07/25/24. *Reglan 5mg tablet give 5mg by mouth before meals related to nausea with vomiting with an order start date of 07/18/24. Record review of Resident #18's medication administration record for 10/01/24-10/31/24, indicated Resident #18 was to receive multiple vitamin with minerals one tablet between 6a-10a and Reglan 5mg one tablet before meals at 07:00 AM, 11:30 AM, and 4:30 PM. During an observation of medication administration on 10/15/24 at 10/15/24 at 08:36 AM, MA X administered the following medications to Resident #18: *Losartan 100mg- 1 tablet *Carvedilol 6.25mg- 1 tablet *B-complex plus vitamin C- 1 tablet *Eliquis 5mg- 1 tablet *Fluticasone 50mcg- 2 sprays in each nostril *Multivitamin- 1 tablet *Hydrochlorothiazide 12.5mg- 1 tablet *MiraLAX 17gms *Active liquid protein- 30mls *methocarbamol 500mg- 1 tablet *Reglan 5mg- 1 tablet Review of medication reconciliation on 10/16/24 revealed Resident #18 had physician's orders for multivitamin with minerals by mouth daily. MA X failed to administer the ordered multivitamin with minerals as she administered a multivitamin tablet. Resident #18 also had an order for Reglan 5mg one tablet before meals and was scheduled for 07:00 AM. MA X failed to administered Resident #18's ordered Reglan before meals as ordered by the physician and within the one hour before and one hour after the prescribed time frame since medication was administered at 08:36 AM, 36 minutes late. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/16/24 at 11:57 AM, MA X opened the 100-200 hall medication cart and took out the multivitamin bottle. MA X said the multi-vitamin with minerals bottle was not on the medication cart. MA X said Resident #18 should have received the multivitamin with minerals tablet as prescribed by the physician. MA X said they had an hour before and an hour after the prescribed time frame to administer a medication. MA X said Resident #18's Reglan was given over an hour from the prescribed time frame. MA X said if the medication was ordered before meals, then it should have been given before meals. MA X said it was necessary to administer the medication before meals because administering it after meals could cause the medication not to work as well. MA X said she was responsible for ensuring medications were being administered as ordered. MA X said she had been checked off on medication administration competency. During an interview on 10/16/24 at 4:28 PM, the DON said she did not have a medication administration via the gastrostomy tube competency skills check off for LVN W or medication administration competency skills check off for MA X. During an interview on 10/17/24 at 11:32 AM, the DON said when peg tube medications were being administered, peg tube placement should be checked via auscultation and residual. The DON said medications should not be cocktailed because it could cause harm or cause a change in condition to the resident. The DON said medications should be crushed individually and mixed with 5-10mls of water. The DON said Resident #57's blood pressure should have been assessed prior to preparing the medications. The DON said if a resident's blood pressure was low, then the blood pressure medications should be held. The DON said LVN W should have prepared the Eliquis to have been administered as it was an anticoagulant medication and not a blood pressure medication. The DON said LVN W was responsible for ensuring medications via the gastrostomy tube were administered as ordered by the physician. The DON said if Resident #57's received his blood pressure medication with his blood pressure being low he was at risk for his blood pressure to drop. The DON said by not checking placement as ordered Resident #57's peg tube could be out of place. The DON said she expected MA X to have administered Resident #18's medications as ordered by the physician. The DON said failure to administer the medications as ordered, placed the resident at risk for medications not to work effectively. The DON said MA X was responsible for ensuring medications were administered as ordered. The DON said competencies should be completed annually and since MA X and LVN W did not have the required competencies mistakes could happen. The DON said she was responsible for ensuring staff was competent in providing the required care to the residents. During an interview on 10/17/24 at 11:36 AM, the Administrator said he expected LVN W and MA X to administer medications as per the physician orders. The Administrator said the nurses should follow best practice and what they have been trained to do. The Administrator said by not administering medications as ordered there was a potential for harm or change in condition. The Administrator said the licensed individual administering the medications was responsible for ensuring the mediations were administered as ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy Administering Medications through an Enteral Tube revised November 2018, indicated . The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Preparation.1. Verify that there is a physician's medication order for this procedure . Follow the medication administration guidelines in policy entitled Administering Medications . 3. Administer each medication separately and flush between medications . Steps in the procedure . 3. Prepare the medication: a. check the label and confirm the medication name and dose with the MAR . 6. Verify placement of feeding tube . 9. Dilute medication: a remove plunger from syringe. Add medication and appropriate amount of water to dilute. b. dilute crushed (powdered) medication with at least 30mls of purified water (or prescribed amount) . 10. Administer each medication separately . 12. Administer medication by gravity flow . 13. If administering more than one mediation, flush with 15mls warm water (or prescribed amount) between medications. Record review of the facility's policy Administering Medications revised April 2019 indicated . Medications are administered in a safe and timely manner, and as prescribed . 4. Medications are administered in accordance with prescriber orders, including any required time frame . 7. Medications are administered within 1 hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 11. The following information is checked/verified for each resident prior to administering medications .b. Vital signs, if necessary .

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review the facility failed to ensure that residents were free of significant medication errors for 1 of 7 residents reviewed for pharmacy services. (Resident #57) The facility failed to ensure LVN W did not prepare to and attempt to administer Resident #57's metoprolol (blood pressure medication) his blood pressure was low on 10/15/24. The facility failed to ensure LVN W prepared and attempt to administer Resident #57's Eliquis (anticoagulant medication) on 10/15/24. These failures could place the resident at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: Record review of Resident #57's face sheet dated 10/17/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), essential hypertension (high blood pressure), congestive heart failure (heart does not pump blood as well as it should), gastrostomy status (surgical opening into the stomach for nutritional support and medication administration), and dysphagia (difficulty swallowing). Record review of Resident #57's quarterly MDS assessment dated [DATE], indicated Resident #57 was rarely/never understood and usually understood others. The MDS assessment indicated Resident #57 had short term and long-term memory problems. The MDS assessment indicated Resident #57 was dependent on staff with eating, oral hygiene, toileting, personal hygiene, and showers. The MDS assessment indicated Resident #57 had a feeding tube. The MDS assessment indicated Resident #57 received anticoagulant and antiplatelet medications within the 7-day look back period. Record review of Resident #57's comprehensive care plan revised on 05/17/24, indicated Resident had a cerebral vascular accident affecting mobility, speech and cognition. The care plan interventions included to give medications as ordered by the physician. Record review of Resident #57's order summary report dated 10/17/24, indicated he had the following orders: *Do not cocktail medications with an order start date of 05/22/24. *May crush or open medications and mix each medication with 5mls of water. Give 5-10 mls water between each medication every shift for enteral administration with a start date of 05/22/24. *Apixaban 5mg give one tablet via g-tube two times a day for anticoagulant with an order start date of 05/22/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Entresto 24-26mg give one tablet via g-tube two times day for chronic heart failure hold if SBP less than 110 or DBP less than 60 with an order start date of 07/25/24. *Metoprolol tartrate 25mg give one tablet via g-tube two times a day for hypertension with an order start date of 05/22/24. Record review of Resident #57's nursing medication administration record for 10/01/24-10/31/24, indicated Resident #57 was scheduled to receive apixaban 5 mg one tablet, Entresto 24-25mg one tablet, and metoprolol 25mg one tablet via g-tube. The record indicated to not cocktail Resident #57's medications and to flush tube with 30mls of before and after medications every shift. The nursing administration record also indicated may crush or open medications and mix each medication with 5mls of water and to give 5-10mls of water between each medication every shift. During an observation of medication administration and an interview on 10/15/24 at 11:05 AM, LVN W obtained Resident #57's following medications: Vitamin C 500mg tablet, multivitamin tablet, thiamin 100mg tablet, aspirin 81 tablet, amiodarone 400mg tablet, metoprolol 25mg tablet, montelukast 10mg tablet, atorvastatin tablet and crushed all medications together in a pill crusher pouch. LVN W said she was not placing the Entresto 24-26mg tablet or the Eliquis 5mg tablet until she obtained Resident #57's blood pressure (Eliquis does not require a blood pressure reading for administration). LVN W obtained Resident #57's blood pressure with readings of 87/48 and pulse of 63. LVN W said she was not administering the Entresto tablet or the Eliquis tablet because Resident #57's blood pressure was low. LVN W and LVN Z applied PPE and entered Resident #57's room. LVN W had the pill crusher pouch with the crushed medications inside in her hand. LVN W obtained a 60 mls syringe, attached it to Resident #57's enteral feeding tube, and checked for residual by pulling back on the syringe. No residual noted. LVN W did not confirm placement via auscultation as ordered by the physician. LVN W then used the syringe and obtained over 60mls of water and flushed Resident #57's gastrostomy tube. LVN W then removed the stopper from the syringe, placed her pointer finger on the tip of the syringe, and poured the crushed medications from the pouch into the syringe. LVN W then applied the stopper to the top of the syringe, turned the syringe upside down, then inverted it into a cup with water, and added approximately 50mls of water into the syringe. LVN W then mixed the medications in the syringe by shaking it. LVN W was in the process of applying the syringe with medications to Resident #57's gastrotomy tube to administer them, when surveyor intervened before the medications were administered. LVN W said she did not remember if she could cocktail Resident #57's medications, but that was what she had been doing. LVN W said she had not checked placement by auscultation as ordered because she had done it that morning. LVN W said she should not have crushed Resident #57's metoprolol tablet with his medications since it was a blood pressure medication and Resident #57's blood pressure was low. LVN W said if she had administered the blood pressure medication Resident #57 was at risk for bis blood pressure bottoming out. LVN W said she did not place the Eliquis tablet in Resident #57's medications because she thought it was for his blood pressure. LVN W said failure to administer the Eliquis placed Resident #57 at risk of having a blood clot since Eliquis was a blood thinner. LVN W said she was responsible for ensuring medications were being administered as ordered by the physician. LVN W said by cocktailing medications Resident #57 was at risk for an adverse reaction. LVN W said by not checking placement as ordered, Resident #57 was at risk for his gastrostomy tube to be out of place. LVN W said she had been checked off on medication administration via the gastrostomy tube. LVN Z said the metoprolol, Entresto and amiodarone were the medications that should have been held and all should have had blood pressure parameters. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 11:32 AM, the DON said medications should not be cocktailed because it could cause harm or cause a change in condition to the resident. The DON said medications should be crushed individually and mixed with 5-10mls of water. The DON said Resident #57's blood pressure should have been assessed prior to preparing the medications. The DON said if a resident's blood pressure was low, then the blood pressure medications should be held. The DON said LVN W should have prepared the Eliquis to have been administered as it was an anticoagulant medication and not a blood pressure medication. The DON said LVN W was responsible for ensuring medications via the gastrostomy tube were administered as ordered by the physician. The DON said if Resident #57's received his blood pressure medication with his blood pressure being low he was at risk for his blood pressure to drop. During an interview on 10/17/24 at 11:36 AM, the Administrator said he expected LVN W to administer medications as per the physician orders. The Administrator said the nurses should follow best practice and what they have been trained to do. The Administrator said by not administering medications as ordered there was a potential for harm or change in condition. The Administrator said the licensed individual administering the medications was responsible for ensuring the mediations were administered as ordered. Record review of the facility's policy Administering Medications revised April 2019 indicated . Medications are administered in a safe and timely manner, and as prescribed . 4. Medications are administered in accordance with prescriber orders, including any required time frame . 7. Medications are administered within 1 hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 11. The following information is checked/verified for each resident prior to administering medications: .b. Vital signs, if necessary .

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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. 47006 Based on observation, interview, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel for 3 of 6 medication carts (treatment cart, 300-400 hall medication cart, and 100-200 nurses' cart) reviewed for pharmacy services. 1. The facility failed to ensure RN D locked the 100-200 nurses' cart when she left it unattended at the nurses' station on 10/14/24. 2. The facility failed to ensure the MDS Coordinator locked the treatment cart when she left it unattended in the hallway on 10/16/24. 3. The facility failed to ensure medication cart for hall 300-400 was secured and unable to be accessed by unauthorized personnel. These failures could place residents at risk of not having the medication available due to possible drug diversion. Findings included: 1. During an observation and interview on 10/14/24 beginning at 10:31 PM, a medication cart was unlocked at the nurses' station. There were no facility staff at the nurses' station. RN D walked up to the nurses' station. RN D stated she was the nurse responsible for the unlocked medication cart. RN D stated medication carts should have been kept locked. RN D stated she forgot to lock the medication cart. RN D stated it was important to ensure medication carts were kept locked to prevent a drug diversion or adverse effects from taking the wrong medications. 46928 2. During an observation and interview on 10/16/24 at 4:28 PM, the MDS Coordinator entered Resident #176's room to flush her PICC line. The MDS Coordinator completed the procedure and went to the treatment cart to obtain disinfectant wipes to clean Resident #176's bedside table. The MDS Coordinator did not lock the treatment cart when she went back inside Resident #176's room to disinfect Resident #176's bedside table and wash her hands. The MDS Coordinator said it was her responsibility to lock the carts when leaving them unattended because residents could get in and get medications. 47612 During an observation and interview on 10/16/2024 at 9:19 a.m., MA R left the medication cart for hall 300 and 400 unlocked on hall 400 while in medication supply. MA R stated the medication cart should be locked. MA R stated she walked off to fast and forgot to lock the medication cart. MA R stated it was important to keep the medication cart locked so no one could take medication from the cart. MA R stated residents could take medication from the cart that was not theirs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 10:07 a.m., the DON stated she expected the staff to always lock the medication carts before walking away. The DON stated it was important to lock the medication carts for safety of the residents and visitors. The DON stated she would monitor by daily rounds. During an interview on 10/17/2024 at 10:07 a.m., the Administrator stated he expected staff to lock the medication cart. The Administrator stated the nursing staff were responsible for locking the medication carts before walking away. The Administrator stated it was important to lock the medication cart to ensure the safety of the drugs. The Administrator stated he would monitor by making rounds to ensure all medications carts were locked. Record review of the facility's policy titled, Administering Medication dated April 2019, revealer During administration of medication, the medication cart was kept closed and locked when out of sight of the medication nurse or aide .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47612 Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 3 of 23 residents (Resident's #6, #14, and #39) reviewed for palatable food. The facility failed to provide palatable food served at an appetizing temperature or taste to Resident #6, Resident #14, and Resident #39, who complained the food was served cold, was bland, and did not taste good. This failure could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. The findings included: During an interview on 10/14/2024 at 3:03 p.m., Resident #14 stated the food was okay, but it was too cold most of the time. During an interview on 10/14/2024 at 3:25 p.m., Resident #6 stated the food had no taste and was overcooked most of the time. During an interview on 10/14/2024 at 3:36 p.m., Resident #39 stated the food was not good, very bland. During an observation and interview on 10/15/2024 at 1:03 p.m., a lunch tray was sampled by [NAME] U and four surveyors. The sample tray consisted of beef stew, which was bland but hot, lettuce which was warm, and carrot cake that was bland. [NAME] U agreed that the food was bland, and the lettuce was warm. During an interview on 10/15/2024 at 2:15 p.m., [NAME] U stated she had just started working at the facility two weeks ago. [NAME] U stated she was responsible for ensuring the food was appropriate temperature and tasted good. [NAME] U stated it was important to ensure food was served at the appropriate temperature and tasted good, so the residents enjoyed eating it and the food did not make them sick. During an observation and interview on 10/16/2024 at 12:57 p.m., a lunch tray was sampled by the Dietary Manager and four surveyors. The sample tray consisted of rotisserie chicken, which was dry, yellow squash, which was bland, steamed rice, which was bland and over cooked, fruit crisp. The Dietary Manager agreed the food was bland and stated she adds seasoning packets on the trays. The Dietary Manager it was hard to please everyone with as many different diets the residents were on. During an interview on 10/16/2024 at 2:30 p.m., the Dietary Manager stated she had received food complaints. The Dietary Manager stated she expected the food to have been served at the appropriate temperatures, looked good, and tasted good. The Dietary Manager stated it was important to ensure the food was served at the correct temperature, looked good, and tasted good so the food did not make the residents sick and so they would not lose weight. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/2024 at 10:35 a.m., the Administrator stated he has a test tray about once a week, and they have been bland. The Administrator stated he expected dietary staff to ensure food was served at appropriate temperatures and was appetizing. The Administrator stated it was important to ensure food was served at correct temperatures, looked good, and tasted good so the residents would eat it and get the proper nutrition. The Administrator stated he would monitor by getting a test tray three days a week and making daily rounds. Record review of the policy Test Tray, dated 10/01/2018, revealed .The facility recognized the importance of routine quality assurance monitoring to ensure that its residents are provided food that is appealing, palatable and served at the correct temperature

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47612 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure hair restraints were worn appropriately by dietary staff. 2. The facility failed to ensure the dishwasher was in correct temperature range of 120 during wash cycle. 3. The facility failed to ensure chemical test strips were used for dishwasher. These failures could place residents at risk for foodborne illness. Findings include: During an observation in the kitchen on 10/14/2024 at 10:20 a.m., revealed [NAME] U was not wearing a hair restraint appropriately while preparing the lunch meal. [NAME] U's hair was visible outside of the hairnet in the back approximately four inches. During an observation in the kitchen on 10/14/2024 at 10:28 a.m., revealed dietary aide S was not wearing a hair restraint appropriately while preparing the lunch meal. Dietary aide S's hair was visible outside of the hairnet in the back approximately three to four inches. During an observation in the kitchen on 10/14/2024 at 10:30 a.m., revealed dishwasher temperature to be 115 during wash cycle and dietary aide S could not find correct chlorine test strips for the dishwasher. During an interview on 10/14/2024 at 11:15 a.m., Dietary aide S stated she did not realize she had hair uncovered. Dietary aide S stated it was important to cover your hair to keep it out of the food. Dietary aide S stated the harm to the resident was they would not want to eat food that had hair in it and lose weight. Dietary aide S stated the temperature for the dishwasher should be above 120 and it was 115. Dietary aide S stated it was important for the dishwasher to be at the correct temperature to sanitize the dishes. Dietary aide stated she uses test strips to check the dishwasher sanitation. Dietary aide S stated if the dishwasher was not at the right temperature residents could get sick. During an interview on 10/14/2024 at 11:45 a.m. the Maintenance Employee T stated the dishwasher was a low temp machine and the temperature should be at 120 during the wash cycle. Maintenance Employee T stated it was important for the dishwasher to be at 120F to kill bacteria. Maintenance Employee T stated the harm was resident could become sick from food borne illnesses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/14/2024 at 1:15 p.m., [NAME] U stated she did not realize her hair was not covered. [NAME] U stated it was important to wear hairnets correctly to keep hair out of the food. [NAME] U stated the residents would not enjoy eating food with hair in it. During an interview on 10/16/2024 at 2:30 p.m., the Dietary Manager stated she expects staff to keep all hair covered. The Dietary Manager stated hairnets were important to ensure no hair got into the food. The Dietary Manager stated if hair was in the food the residents may not want to eat. The Dietary Manager stated she had shown the dietary staff several times where the test strips were and how to use them. The Dietary Manager stated it was important to make sure the dishes were sanitized to prevent cross contamination. During an interview on 10/17/2024 at 10:35 a.m., the Administrator stated he expected the dishwasher to reach the correct temperature for sanitation and the dietary staff to use the correct chlorine test strip. The Administrator stated it was important to monitor the temperature to verify the correct sanitation. The Administrator stated he would monitor by making daily rounds. Record review of the facility's policy Mechanical Cleaning and Sanitation of Utensils, dated 10/01/2018, revealed If a machine that uses chemicals for sanitizing is in use, follow the guidelines .The temperature of the wash water must be at least 120 F A test kit or other devices that accurately measure the parts per million concentration of the solution must be available and used

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 4 residents (Resident #14) reviewed for hospice services. The facility did not ensure Resident #14's hospice records were a part of their records in the facility. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. The findings included: Record review of the face sheet, dated 10/17/2024, revealed Resident #14 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of parkinsonism (clinical syndrome characterized by the four motor symptoms found in Parkinson's disease: tremor, bradykinesia (slowed movements), rigidity, and postural instability). The face sheet further revealed Resident #14 received hospice services. Record review of the quarterly MDS assessment, dated 10/01/2024, revealed Resident #14 had clear speech and was understood by others. The MDS revealed Resident #14 was able to understand other. The MDS revealed Resident #14 had a BIMS score of 11, which indicated moderately impaired cognition. The MDS revealed Resident #14 received hospice services at the facility. Record review of the comprehensive care plan, revised 06/02/2023, revealed Resident #14 had a terminal prognosis and was receiving hospice services. Record review of the order summary report, dated 10/17/2024, revealed Resident #14 had an order, which started on 05/01/2024, for hospice services. Record review of Resident #14's hospice binder, accessed on 10/16/2024, revealed no certification of terminal illness. The hospice binder further revealed the plan of care and medication were not updated since 08/22/2024. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 beginning at 10:17 AM, Hospice RN AA stated every other week after the plan of care meetings the hospice nurse was responsible for dropping off the updated paperwork. Hospice RN AA stated the hospice nurse dropped off the paperwork and placed it in the binder and the facility nurse signed off on a paper that it was dropped off. Hospice RN AA stated she was covering for the hospice nurse that usually came because she was on vacation. Hospice RN AA stated Resident #14's hospice binder did not contain the updated information. Hospice RN AA stated it was important to ensure the facility had the updated hospice documentation and plan of care to ensure continuity of care and communication with the facility. During an interview on 10/17/2024 beginning at 12:33 PM, LVN A stated the hospice nurses were responsible for leaving the documentation in the hospice binders at the nurses' station. LVN A stated she never received paperwork from the hospice company. LVN A stated she only signed the tablets used by the hospice company to verify they were at the facility. LVN A stated she did not have to sign a paper to verify the documentation was placed in the hospice binder. During an interview on 10/17/2024 beginning at 1:37 PM, the Corporate Regional Nurse stated she did not have a policy that stated the facility had to check the hospice binder to make sure the paperwork was current and up to date. During an interview on 10/17/2024 beginning at 1:37 PM, the DON and Administrator were interviewed together. The DON and Administrator were unsure who was responsible for ensuring the facility had the most updated information from the hospice company. The Administrator stated typically Admissions then Medical Record would have been responsible. The DON stated it was important to ensure the facility had access to the updated hospice paperwork for coordination or continuity of care.

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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** 46892 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 5 residents (Resident #43 and Resident #176) and 2 of 4 clean linen carts (Hall 300 and Hall 400 clean linen carts) in the facility reviewed for infection control practices and transmission-based precautions. 1. The facility failed to ensure the MDS Coordinator applied PPE prior to flushing Resident #176's PICC line on 10/16/2024 2. The facility failed to ensure CNA M changed her gloves and performed hand hygiene and did not touch the wipes container with dirty gloves while providing incontinent care to Resident #43 on 10/14/2024. 3. The facility failed to ensure Hospice Aide L did not carry unbagged, dirty linen in her hand down the hall on 10/16/2024. 4. The facility failed to ensure CNA K did not leave a bag with trash and an unbagged bed pad on the floor in Resident #43's room after providing incontinent care on 10/16/2024. 5. The facility failed to ensure the clean linen carts on Hall 300 and Hall 400 were covered. These failures could place residents at risk for cross-contamination and the spread of infection. Findings included: 1. Record review of Resident #176's face sheet dated 10/17/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (a brain dysfunction caused by various disease toxins in the body), essential hypertension (high blood pressure), pneumonia (lung infection), and chronic obstructive pulmonary disease (lung condition caused by damage to the airways that limit airflow). Record review of Resident #176's admission MDS assessment dated [DATE], indicated Resident #176 was able to make herself understood and understood others. The MDS assessment indicated Resident #176 had a BIMS score of 11, indicating her cognition was moderately impaired. The MDS assessment indicated Resident #176 received IV medications and had an IV access on admission and while a resident at the facility. The MDS assessment indicated Resident #176 had a PICC line on admission. Record review of Resident #176's comprehensive care plan dated 10/08/24, indicated Resident #176 was on antibiotic therapy related to UTI, CRE (carbapenem-resistant enterobacterales, bacteria that is resistant to most antibiotics) noted in urinalysis. The care plan interventions included to administer antibiotic medications as ordered by the physician. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #176's comprehensive care plan dated 10/09/24, indicated Resident #176 was on enhanced barrier precautions (EBP) related to risk for MDRO due to indwelling medical device PICC line. The care plan interventions included for enhanced barrier precautions to be utilized during ADLs but not limited to: dressing, bathing, transferring, providing hygiene, changing linens/briefs or when toileting, care of indwelling medical device and wound care of chronic wounds. Record review of Resident #176's order summary report dated 10/17/24, indicated Resident #176 had an order for normal saline flush use 10mls IV every 8 hours for PICC line with an order start date of 10/01/24. Resident #176 also had an order for contact isolation precautions strict isolation required in which all care, therapy, dining, and other services were provided in private room related to an active infection. Record review for Resident #176's nursing medication administration record for 10/01/24-10/31/24, indicated Resident #176 had been receiving 10mls of normal saline flushes to her PICC line 3 times a day. During an observation and interview on 10/16/24 at 4:28 PM, the MDS Coordinator entered Resident #176's room to flush her PICC line. The MDS Coordinator did not apply PPE before entering Resident #176's room. The MDS Coordinator said she should have worn PPE before she went inside Resident #176's room and provided care due to Resident #176 being on contact precautions. The MDS Coordinator said by not applying PPE prior to providing care placed her at risk for getting blood spilled on her and was an infection control issue. The MDS Coordinator said it was her responsibility to ensure PPE was worn when providing care to residents that were on isolation. During an interview on 10/17/24 at 11:16 AM, the ADON said she expected the MDS Coordinator to have worn PPE prior to flushing Resident #176's PICC line to ensure she did not get anything around the PICC line. The ADON said failure to not use PPE was an infection control issue and the nurse was responsible for ensuring PPE was worn when providing care. During an interview on 10/17/24 at 11:46 AM, the DON said she expected her staff to wear PPE when providing care to a resident who was contact isolation. The DON said by the staff not wearing the appropriate PPE when providing care placed the residents at risk for spread of infection. The DON said everyone that provided care to a resident on isolation was responsible for ensuring PPE was worn. During an interview on 10/17/24 at 11:49 AM, the Administrator said he expected the staff to wear PPE when providing care to a resident on isolation. The Administrator said by not using PPE there was a potential to spread infection. The Administrator said everyone providing care to a resident on isolation was responsible for ensuring PPE was worn. 2. Record review of a face sheet dated 10/15/2024 indicated Resident #43 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (right sided weakness and paralysis after unspecified disease affecting the brain) and chronic respiratory failure (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #43 was able to make herself understood and understood others. The MDS assessment indicated Resident #43 had a BIMS score of 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #43 required partial/moderate assistance for toileting, bathing, and personal hygiene. The MDS assessment indicated Resident #43 received oxygen therapy while a resident at the facility. Record review of Resident #43's care plan date initiated 07/06/2024 indicated she had an ADL self-care performance deficit related to a stroke with right sided weakness. Resident #43's care plan indicated she required assistance of one staff member for personal hygiene and toilet use. Resident #43's care plan indicated the resident had the potential for bowel incontinence related to decreased mobility to provide peri care after each incontinent episode. During an observation on 10/14/2024 starting at 11:15 PM, CNA M provided incontinent care to Resident #43. CNA M applied gloves and removed Resident #43's brief. CNA M placed the packet of wipes on Resident #43's bed. CNA M wiped Resident #43's front peri area and then turned her on her side. CNA M removed the dirty brief and disposed of it. CNA M touched the wipes container with her dirty gloves and removed more wipes from the wipes container. CNA M wiped Resident #43's buttocks. CNA M grabbed the clean brief with her dirty gloves. CNA M failed to change gloves and perform hand hygiene prior to touching the clean brief and applying it. CNA M applied the clean brief and clen bed pad. CNA M applied cream to Resident #43's buttocks with one hand. CNA M then removed the glove that she had applied the cream on Resident #43's buttock and kept the other glove on. CNA M finished fastening the clean brief with one dirty, gloved hand and repositioned Resident #43 in the bed. CNA M touched Resident #43's remote with her dirty glove and opened the drawers to her nightstand. CNA M placed the packet of wipes on top of Resident #43's nightstand. CNA M then gathered the dirty linens and trash to exit the room. CNA M removed her other glove and disposed of it. CNA M took the dirty linens, trash, and the wipes container and exited the room. CNA M returned the wipes container to the linen cart in the hallway and disposed of the dirty linen and trash and performed hand hygiene. CNA M said gloves should be changed and hand hygiene performed after removing the dirty brief and before applying the clean brief. CNA M said she should not have repositioned Resident #43 and touched her nightstand and wipes container with her dirty gloves. CNA M said she was in a hurry and that was why she had not performed appropriate glove changes and hand hygiene. CNA M said she was not sure what the correct way to use the wipes was. CNA M said she had asked other staff at the facility how she should take the wipes into the room and had not received a clear response. CNA M said taking the wipes container into the room and placing it on the bed and on the nightstand and then returning it to the linen cart was a risk for cross contamination. CNA M said not performing hand hygiene and glove changes during incontinent care placed the residents at risk for urinary tract infections. During an observation on 10/16/2024 at 1:42 PM, Hospice Aide L was observed walking to the end of the hall wearing gloves, in one hand she was carrying a bed pad with sheets rolled up in the middle. Hospice Aide L disposed of the dirty linens in the dirty linen closet at the end of the hall. Hospice Aide L said the bed pad and sheets she was carrying were dirty, and they should have been carried down the hall in a bag. Hospice Aide L said she did not have any bags in the room where she provided care. Hospice Aide L said dirty linens should be carried in a bag to prevent cross contamination and for infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676497	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health and Wellness	110 N State Hwy 274 Kemp, TX 75143

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/16/2024 at 1:55 PM, there was a clear bag with dirty wipes and a dirty brief in it on top of a bed pad on the floor in the entry to Resident #43's room. Resident #43 said she did not know it had been left there that she was changed after lunch. CNA K said she had left the trash and bed pad there because there were lunch trays on the hall when she changed Resident #43. CNA K said the bed pad was used to place under Resident #43 while she provided incontinent care, but it was not wet and that was why she did not bag it. CNA K said the trash and linens should not be left on the floor in the residents' rooms because it was gross. During an interview on 10/17/2024 at 12:19 PM, the DON said during incontinent care the CNAs should ensure they used proper incontinent care and infection control standards. The DON said gloves should be changed and hand hygiene performed when touching the dirty and then touching the clean. The DON said it was important for incontinent care to be performed appropriately, gloves to be changed and hand hygiene performed during incontinent care to prevent urinary tract infections. The DON said wipes should either be pulled and placed in a clean container or bag prior to entering the resident's room and the container or bag taken into the resident's room or the wipes container taken into the room and left in the room. The DON said it was important not to take the wipes container into the resident's room and then take it out of the room because of cross contamination and for infection control. The DON said the dirty linen should be bagged prior to leaving the room. The DON said after incontinent care the trash and dirty linen should be disposed of properly, not left in the resident's room. The DON said it was important for the dirty linen to be bagged and disposed of and for the trash to be disposed of for infection control and to prevent cross contamination. The DON said she tried to pop in and observe the CNAs provide incontinent care at least once a week. During an interview on 10/17/2024 at 12:50 PM, the Administrator said he expected for the staff to follow the policies and procedures they were trained on. The Administrator said the nursing department was responsible for ensuring the CNAs performed proper incontinent care and disposed of linens and trash properly. The Administrator said it was important for the infection control policies and procedures to be followed to decrease the risk of infection. 3. During an observation on 10/14/2024 at 10:30 p.m., a clean linen cart was on hall 400 with the cover open. During an observation on 10/14/2024 at 10:50 p.m., a clean linen cart was on hall 300 with cover was open. During an interview on 10/14/2024 at 10:40 p.m., CNA O stated the clean linen cart cover should be closed. CNA O stated it was important to keep the cover closed so the clean linens would not get contaminated. CNA O stated the failure would be the residents could get rashes or urinary tract infection if the linens became contaminated. During an interview on10/14/2024 at 10:55 p.m., CNA M stated the clean linen cart cover should be closed. CNA M stated it was important to keep the cover closed to prevent the residents from getting things from the cart. CNA M stated the failure would be if the residents touch the clean linens, it could cause infections. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lakeside Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 110 N State Hwy 274 Kemp, TX 75143	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/14/2024 at 11:06 p.m., RN Q stated the clean linen cart cover should be closed. RN Q stated the CNAs were responsible for closing the cover when they are done. RN Q stated the charge nurse was responsible for making sure the CNAs do their jobs. RN Q stated it was important to keep the cover closed for infection control. RN Q stated the failure was the linens could become soiled. During an interview on 10/17/2024 at 10:07 a.m., the DON stated she expected the staff to close the cover to the clean linen cart when not being used because that was part of infection control. The DON stated it was important to keep the cover closed for infection control. The DON stated there could be potential harm to the residents. The DON stated she would monitor by in-service and making rounds. During an interview on 10/17/2024 at 10:35 a.m., the Administrator stated he expected the staff to close the clean linen cart cover when not in use. The Administrator stated it was important to close the cover, so the clean linens did not get debris on them. The Administrator stated he would assume there was no harm to the resident by leaving the cover to the clean linens open. The Administrator stated he would monitor by making rounds. Record review of the policy Linens, undated, revealed .Staff members will follow the community's protocols for handling linens, and linens will be processed, transported, stored, and handled properly. Record review of the facility's policy Administering Medications revised April 2019 indicated . Medications are administered in a safe and timely manner, and as prescribed . 25. Staff follows established community infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Record review of the facility's policy Isolation-Categories of Transmission-Based Precautions revised October 2018, indicated . Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents .Contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the residents environment . 4. Staff and visitors will wear gloves (clean, non-sterile) when entering the room . 5. Staff and visitors will wear disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed . During an interview on 10/17/2024 at 1:31 PM, the policy for incontinent care was requested and the Regional Compliance Nurse provided the policy titled, Basic Standards for Clinical Procedures, last revised July 2017. The policy indicated, Appropriate care is taken to put forth the resident's right to privacy and dignity, as well as the resident's health and safety are protected during the performance of any clinical care or procedure . j. Apply appropriate Personal Protective Equipment (gloves, gown, mask, etc.) as required by the procedure . c. Based upon the type of procedure and work surface: Clean and sanitize the resident's the area as needed and discard any used supplies. Remove any equipment and clean as appropriate. d. Remove soiled linens and place in an appropriate receptacle. e. Remove personal protective equipment and discard appropriately . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46928 47612

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 46892 Based on interview and record review the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property for 1 of 6 (RN N) employees reviewed for staff training. The facility failed to ensure RN N received abuse training. This failure could place residents at risk of abuse, neglect, and exploitation and a poor quality of care by staff with inadequate training. Findings included: During an interview on 10/16/2024 at 10:20 AM, the DON said the facility did a lot of training on abuse upon hire and the facility provided frequent in-services on abuse. The DON said for staff that was employed through an agency the agency did their abuse training and checked their backgrounds. The DON said they tried to in-service the agency staff when they gave in-services about abuse and agency staff were present in the facility at the time of the in-service. The DON said she was not sure if RN N had received any abuse training by the facility. During an interview on 10/16/2024 at 10:54 AM, the Administrator said they were continually monitoring for abuse and neglect daily and in-serviced the facility staff frequently on abuse and neglect. The Administrator said the abuse training for agency staff was completed by the staffing agency. The Regional Compliance Nurse was with the Administrator during the interview, and she said that when agency staff went to the facility to work there was a training packet the facility should have them complete. The training packet was specifically for agency staff, and it contained abuse training for them. The Regional Compliance Nurse said she did not know if the facility had completed this for RN N. The Administrator said he had reached out to the staffing agency RN N was employed by to get her abuse training, and he would check with human resourced to see if RN N had completed the packet. During an interview on 10/16/2024 at 4:13 PM, the Administrator said the staffing agency had not sent him RN N's abuse training yet, and he did not have any abuse training RN N had completed at the facility. Abuse training from the staffing agency for RN N was not received upon exit of the facility. During an interview on 10/17/2024 at 12:55 PM, the Administrator said he expected for all the staff to be properly trained on abuse and neglect. The Administrator said human resources was doing the abuse and neglect training. The Administrator said it was important for the staff to complete abuse and neglect training to prevent abuse and neglect to the residents. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 1:26 PM, Human Resources said she completed abuse training during orientation. Human Resources said she did not do anything with agency staff. Human Resources said the Staffing Coordinator completed a check off list with them, and the Staffing Coordinator kept up with it. Human Resources said it was important for abuse and neglect training to be completed so the residents were not abused and neglected, and this was the residents' home and if the staff see abuse or neglect, they needed to intervene appropriately. During an interview on 10/17/2024 at 1:35 PM, the Staffing Coordinator said prior to this week they did not have anything in place for the abuse and neglect training for agency staff. The Staffing Coordinator said sometimes agency staff would sign abuse and neglect in-services. The Staffing Coordinator said she did not have any abuse trainings for RN N. The Staffing Coordinator said it was important for the staff to complete abuse and neglect trainings so none of the residents were abused or neglected. Record review of the facility's Resident Abuse and Neglect Policy 2021, indicated, .All new and existing team members receive periodic in-service training relative to resident rights and our Facility's abuse prevention program policies and procedures 1. Associates are required to attend our Facility's resident rights and abuse prevention program and dementia management (communication & caring for the cognitively Impaired) in-service training sessions before having any resident contact .