STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745050	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing and Rehabilitation Center	1555 Bandera Hwy Kerrville, TX 78028

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on interviews and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #1) of 4 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #1 was coded on her Quarterly MDS assessment, signed as completed on [DATE], for a psychiatric/mood disorder, an anxiety disorder diagnosed [DATE]. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: Record review of Resident #1's Admission Record, dated [DATE], reflected a [AGE] year-old female. She was initially admitted on [DATE] and readmitted on [DATE]. She discharged on [DATE]. Record review of Resident #1's Diagnosis Report, dated [DATE], reflected a principle diagnosis of Alzheimer's Disease (a progressive disease that affects memory and other important mental functions) with onset dated [DATE], a diagnosis of anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) with onset dated [DATE], a diagnosis of age-related osteoporosis (brittle or fragile bones) without current pathological fracture (a type of broken bone that occurred due to a disease or condition that weakens the bone, rather than from an injury) with onset dated [DATE], and a diagnosis of cognitive communication deficit (difficulty communicating due to injury to the brain) with onset dated [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated [DATE] and signed as completed on [DATE] by the MDS Nurse and the DON, reflected assessment observation end date of [DATE]. Resident #1 had a BIMS score of 3 indicating she was severely cognitively impaired. Under Active Diagnoses in the last 7 days, she was not documented under Psychiatric/Mood Disorder as having had an anxiety disorder. Under High-Risk Drug Classes: Use and Indication, she was documented as taking with an indication noted for antianxiety medications. Record review of Resident #1's Order Recap Report, orders dated [DATE]- [DATE], reflected the order Ativan [a medication used to treat anxiety disorders] Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 8 hours as needed for restlessness for 14 Days, start date of [DATE], and an end date of [DATE]. (continued on next page)

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's [DATE]- [DATE] MAR, dated [DATE], reflected Resident #1 was ordered Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 8 hours as needed for restlessness for 14 Days, start date of [DATE] at 01:00 p.m., and an end date of [DATE] 02:07 p.m. Resident #1 was documented to have received the medication twice on [DATE], once at 09:37 a.m. and a second time at 07:50 p.m. Resident #1 was unavailable for observation or interview. Record review of Resident #1's Progress Note, dated [DATE] by LPN A, reflected Resident #1 had died and been pronounced by a hospice nurse on [DATE] at 08:53 a.m. During an interview on [DATE] at 03:14 p.m., Resident #1's representative revealed she was aware of Resident #1's new medications and knew Resident #1 had had a change in behavior which was expected due to her condition. During an interview on [DATE] at 03:56 p.m., the MDS Nurse revealed she believed she was responsible for the accuracy of the MDS Assessments. She stated the facility had a contracted company that would complete audits of the MDS Assessments to monitor the MDS Assessments for accuracy. She stated that after she had completed a MDS Assessment, she would let the DON know that the assessment was ready for review and to be signed. The MDS Nurse revealed her process for documenting a resident's psychiatric/mood disorder would be to review the documentation provided by the physicians, by the contracted psychiatric services company, and by hospital staff if available. She stated Resident #1 having not been documented as having had an anxiety disorder must have been an oversight on her part. She stated it would not have impacted the care provided to Resident #1, but it might have impacted the facility's reimbursement for Resident #1's care. During an interview on [DATE] at 04:46 p.m., the DON revealed the MDS Nurse was responsible for the accuracy of the MDS Assessments but that she would also review the Assessments with the MDS Nurse. She revealed the facility had a company that was auditing the MDS Assessments for accuracy and the facility had an improvement plan in place because the facility knew that the MDS Assessments' accuracy was not where they needed it to be. The DON revealed her process for reviewing a resident for psychiatric/mood disorders would be by reviewing the resident's medications. When asked about the impact on the resident for the diagnosis to not be documented, the DON responded that the facility was working diligently to get those right. Record review of the facility's policy, Resident Assessments, dated revised [DATE], reflected: 8. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46447 Based on observation, interview, and record review, the facility failed to post daily information that included the facility name, current date, total number and actual hours worked by registered nurses, licensed practical or licensed vocational nurses, certified nurse aides directly responsible for resident care per shift and the resident census for 4 days (05/10/2025, 05/11/2025, 05/12/2025, and 05/13/2025) of 4 days reviewed. The facility did not post the required current nurse staffing information from 05/10/2025 through 05/13/2025. This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census. The findings included: During an observation on 05/13/2025 at 04:17 p.m., a document labeled with the facility name and dated 05/09/2025 was posted in a plastic protector against the wall across from the nurses' station and outside the DON's office. The document included the staff titles: Registered Nurse, Licensed Vocational Nurse, Certified Nurse Aide, Treatment Nurse, and Training. The document included the number of staff under each title, the number of hours, the total number of hours worked for each staff title type, the total number of hours worked, and the daily census. The document did not include information regarding the care provided per shift. During an interview on 05/13/2025 at 04:19 p.m., LPN B revealed the location of the document was the only location she had seen it posted. She revealed the DON posted the document. During an interview on 05/13/2025 at 04:20 p.m., the DON revealed the nurse staffing and census document was posted outside her office. She stated she believed it might not be updated. She stated she had printed out the document for the current day that morning, but the facility printers had been acting up. During an interview on 05/13/2025 at 04:30 p.m., the DON revealed she knew the posted document was dated 05/09/2025. She revealed that she normally posted the document first thing in the morning and did not know why the document was not posted over the weekend. She stated with the facility having had a change in ownership, the nurses have had difficulty getting documents printed. During an interview on 05/16/2025 at 04:46 p.m., the DON revealed she was responsible for posting the daily nurse staffing and census document. She stated the weekend supervisor was responsible for posting the document on the weekends. She stated her back-up for this responsibility would be the ADON. She stated the document was not posted over the weekend due to the printers switching over to a new system and the staff did not have access to the printers. She stated the posting having not been updated would not have impacted the residents' care. She stated that the facility staffing normally stayed consistent. She stated the facility was typically overstaffed due to the resident census having frequent changes and the facility having had many skilled residents. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Record review of the facility's policy, Posting Direct Care Daily Staff Numbers, dated revised August 2022, reflected: Policy Statement Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation 1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. 2. Directly responsible for rident care .Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following: . d. Twenty-four (24)-hour shift schedule operated by the facility; e. The shift for which the information is posted; f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff); g. The actual time worked during that shift for each category and type of nursing staff; and h. Total number of licensed and non-licensed nursing staff working for the posted shift. 3. Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on interviews and record reviews, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 2 of 4 residents (Resident #1 and Resident #2) reviewed for clinical records. 1. The facility failed to ensure Resident #1's pain status was accurately documented on [DATE] and [DATE]. 2. The facility failed to ensure Resident #1's Medication Administration Record (MAR) reflected the administration of Tylenol (medication to treat pain) was accurately documented on [DATE] and [DATE]. 3. The facility failed to ensure Resident #1's weekly skin assessments were documented in her medical record for 2 (the weeks of: [DATE] and [DATE]) of 14 weeks. 4. The facility failed to ensure Resident #2's weekly skin assessments were documented in her medical record for 3 (the weeks of: [DATE], [DATE], and [DATE]) of 13 weeks. These failures could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings included: 1. Record review of Resident #1's Admission Record, dated [DATE], reflected a [AGE] year-old female. She was initially admitted on [DATE] and readmitted on [DATE]. She discharged on [DATE]. Record review of Resident #1's Diagnosis Report, dated [DATE], reflected a principle diagnosis of Alzheimer's Disease (a progressive disease that affects memory and other important mental functions) with onset dated [DATE], a diagnosis of anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) with onset dated [DATE], a diagnosis of age-related osteoporosis (brittle or fragile bones) without current pathological fracture (a type of broken bone that occurred due to a disease or condition that weakens the bone, rather than from an injury) with onset dated [DATE], and a diagnosis of cognitive communication deficit (difficulty communicating due to injury to the brain) with onset dated [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated [DATE] and signed as completed on [DATE] by the MDS Nurse and the DON, reflected assessment observation end date of [DATE]. Resident #1 had a BIMS score of 3 indicating she was severely cognitively impaired. She had not received a pain medication regimen or received PRN pain medications. She had denied pain in the last 5 days and did not have any pressure ulcers/injuries, venous or arterial ulcers, or other ulcers, wounds, or skin problems. Record review of Resident #1's Order Recap Report, orders dated [DATE]- [DATE], reflected: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the order Pain Assessment to be completed every shift. every shift [sic], start date [DATE], and an end date of [DATE]; - the order xray [sic; procedure to generate images of the tissues and structures inside the body] of lumbar spine d/t fall, pain, order date [DATE], and an end date of [DATE]; - the order Bilateral hip and pelvic xray [sic] DX pain, order date [DATE], and an end date of [DATE]; - the order XRAY [sic] Lumbar region DX: Fall/ Complaint of pain, order date [DATE], and an end date of [DATE]; and - the order Tylenol Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain, order date [DATE], and an end date of [DATE]. Record review of Resident #1's Witnessed Fall Incident Report, dated [DATE] at 03:00 a.m., reflected Resident #1 had a witnessed fall, lost her balance and fell on to her bottom. She was noted to have denied pain and no injuries noted at the time of the incident. Record review of facility Day and Night Shift Schedules, dated [DATE] to [DATE] revealed the nurse staffing for Resident #1's assigned was: - LPN A worked the day shift on [DATE], [DATE], and [DATE], - LPN F worked the night shift on [DATE], - RN C worked the day shift on [DATE], - LPN D worked the night shift on [DATE] and [DATE], - the DON worked the day shift on [DATE], and - LPN E worked the night shift on [DATE]. Record review of Resident #1's Progress Notes, dated [DATE] to [DATE] only revealed the following notes regarding Resident #1 expressing pain: - the Infection Note, dated [DATE] at 08:02 a.m. by LPN A, reflected .no c/o pian [sic] or discomfort., - the Progress Note, dated [DATE] at 01:57 p.m. by the ADON, reflected IDT team met regarding resident's recent fall on [DATE]. Team decided for intervention: Nursing staff to recollect urine for follow up lab and increased confusion. Resident has no visible signs of injury, yet has complaints of pain to Left [sic] hip, Left hipXRAY [sic] negative. Resident continues to have complaint of pain to lumbar region, XRAY [sic] ordered., and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the [EMR evaluation tool] SBAR Summary for Providers note, dated [DATE] at 12:54 p.m. by LPN A, reflected The Change In Condition/s reported on this CIC Evaluation are/were: Altered mental status Pain (uncontrolled) Other change in condition .-Pain StatusEvaluation [sic]: Does the resident/patient have pain? Yes .resident noted to be tense with facial grimace and moaning with movement or touch . Record review of Resident #1's [DATE]- [DATE] NMAR, dated [DATE], reflected Resident #1 was ordered Pain Assessment to be completed every shift every shift [sic], start date of [DATE] at 06:00 p.m., and an end date of [DATE] at 08:57 a.m. Resident #1 was documented as at a pain level of 0 during every **Day shift from [DATE] to [DATE] and during every **Nig shift from [DATE] to [DATE]. LPN A documented Resident #1's pain level at 0 for the **Day shift on [DATE], [DATE], and [DATE]. RN C documented Resident #1's pain level at 0 for the **Day shift on [DATE]. The DON documented Resident #1's pain level at 0 for the **Day shift on [DATE]. LPN D documented Resident #1's pain level at 0 for the **Nig shift on [DATE] and [DATE]. LPN E documented Resident #1's pain level at 0 for the **Nig shift on [DATE]. During an interview on [DATE] at 02:33 p.m., LPN A revealed she worked the day shift on [DATE], prior to Resident #1's fall, the day shift on [DATE], the day prior to Resident #1 having been sent to the hospital, and the day shift on [DATE], the shift Resident #1 was sent to the hospital. She revealed she was the nurse that reported Resident #1 had a change in condition which resulted in the order to send Resident #1 to the hospital. LPN A revealed Resident #1 was fine on Saturday and Sunday, [DATE] and [DATE]. She revealed Resident #1 was her normal self, up and walking around on Wednesday, [DATE]. LPN A revealed when she came into work on Thursday, [DATE], Resident #1 was asleep in bed. She revealed around lunch time, she observed a change in Resident #1's status and noticed Resident #1 was hurting a lot. She revealed Resident #1 was unable to tell her where the pain was located. She revealed she received an order to send Resident #1 out to the hospital for the change in condition. LPN A did not reveal why she documented 0 for Resident #1's pain scale on [DATE] day shift NMAR. During an interview on [DATE] at 02:48 p.m., LPN E revealed she worked the night shift on Wednesday, [DATE], the shift prior to Resident #1 having been sent to the hospital. She revealed Resident #1 was her normal self-prior to her going to bed that night. She revealed Resident #1 woke up a few hours later with restlessness, which was common for her. She revealed Resident #1 seemed to have expressed that she was experiencing pain but Resident #1 was primarily restless and anxious. She revealed Resident #1 was unable to communicate where the pain was located or what it was from. LPN E did not reveal why she documented 0 for Resident #1's pain scale on [DATE] night shift NMAR. During an interview on [DATE] at 03:43 p.m., LPN F revealed she worked the shift in which Resident #1 had a fall, [DATE] night shift. She revealed the fall was witnessed by herself and a CNA. She revealed Resident #1 was awake and walking around during the night, which was typical behavior for her, and Resident #1 started to lean against the nurses' station and kind of sat down or her legs gave out. LPN F stated Resident #1 might have hit her tail bone but was kind of leaning back during the fall. She stated she and the CNA both repeatedly asked Resident #1 if she was in pain, and she said no. She stated Resident #1 replied that she was okay. She revealed no injuries were found following her visual assessment and Resident #1 was able to walk back to her room on her own. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 08:45 p.m., LPN D revealed he worked the night shifts for Monday and Tuesday, [DATE] and [DATE]. He revealed Resident #1 was up and walking around during his shifts and yelling out that she wanted to go home, which he revealed were common behaviors for her. He revealed Resident #1 did not have any other pain indicators that he observed. During an interview on [DATE] at 09:56 a.m., RN C revealed she worked the day shift on Monday, [DATE], the shift after Resident #1's fall. She revealed the prior shift nurse, LPN F, had reported to her that Resident #1 had had a fall and was up most of the night. She revealed Resident #1 slept most of the morning of [DATE], but she got up and walked to lunch. RN C revealed Resident #1 did not complain of pain to her and she did not observe Resident #1 having shown any indicators for pain. She revealed the CNAs for her shift did not report to her any observed injuries or indicators or complaint of pain. During an interview on [DATE] at 01:42 p.m., MD G revealed she was Resident #1's physician. She revealed she would not know without looking at her documentation if anyone reported Resident #1 had pain; however, she knew Resident #1 did not have any significant pain with deep breathing. She revealed Resident #1 did not have any breathing issues or severe pain prior to the morning of her change of condition, [DATE]. During an interview on [DATE] at 02:48 p.m., NP H revealed she worked with MD G. NP H revealed she was at the nursing facility the morning Resident #1 had her change of condition and was sent out, Thursday [DATE]. She revealed she observed Resident #1 had a change of condition, she was in a wheelchair, lethargic (having little energy), not responsive or opening her eyes, pale, and diaphoretic (excessive sweating for no apparent reason). NP H revealed she did not observe any signs Resident #1 was in pain or in respiratory distress but was told by the morning nurse that Resident #1 had pain when they got her up that morning. NP H revealed she did not recall the staff mentioning Resident #1 having had pain recently or prior to that morning, [DATE]. She revealed she was only aware of the acute change in pain for that morning. NP H revealed she did not recall when or who requested Resident #1 to have an order for PRN Tylenol for pain. During an interview on [DATE] at 04:08 p.m., the ADON revealed she did not know why the nurses had documented in the NMAR that Resident #1's pain was at 0. She revealed that perhaps they, the nurses, documented 0 because Resident #1 did not verbalize pain. She revealed for Resident #1's pain, they had x-rays taken. She revealed the x-rays were ordered due to the way Resident #1 was sitting. She revealed the hip x-ray was negative, but they also did a lumbar x-ray, which was found to be negative, for further testing. During an interview on [DATE] at 04:46 p.m., the DON revealed she did not receive reports that Resident #1 was in pain. She revealed she did not observe any difference in Resident #1's behaviors prior to the day Resident #1 was sent out, [DATE] and that Resident #1 was able to tell you if she was in pain. The DON revealed she was able to see Resident #1 on the day she was sent out, and Resident #1 was clearly different from the day prior. The DON revealed Resident #1's change was sudden, because she had observed Resident #1 up and walking around the night prior. The DON revealed the ADON put in the orders for the x-rays with the mention of pain because Resident #1 was grimacing. The DON revealed she had not seen Resident #1 grimace. The DON revealed the ADON put the orders in for pain because she, the ADON, did not know what else to put. She revealed that they use that wording for coding for insurance. The DON revealed her expectation was for the nurses to put 0 under the pain assessment in the NMAR if the resident is not in pain. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #1's [DATE]- [DATE] MAR, dated [DATE], reflected Resident #1 was ordered Tylenol Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain, start date of [DATE] at 01:00 p.m., and an end date of [DATE] at 08:57 a.m. Resident #1 was not documented to have received the medication. The spaces to document the medication administration were blank or empty. During an interview on [DATE] at 02:48 p.m., LPN E- revealed she recalled administering Resident #1 Tylenol during the night shift on [DATE] due to Resident #1 indicating she was in pain. During an interview on [DATE] at 08:45 p.m., LPN D revealed he was Resident #1's nurse on the night shifts of Monday ([DATE]), Tuesday ([DATE]), Saturday ([DATE]), and Sunday ([DATE]). He revealed he had administered Tylenol to Resident #1. He revealed Resident #1 would not ask for pain medication, but she had an order and Tylenol seemed to help. He did not reveal when he had administered Tylenol to Resident #1, what specific symptom he was addressing with the administration, or how he documented that he administered Tylenol. During an interview on [DATE] at 01:42 p.m., MD G revealed she expected for any medications given, the administration would be documented on the MAR that it was given. She revealed that if the MAR was blank, she would determine that that meant no Tylenol had been provided. During an interview on [DATE] at 03:07 p.m., LPN E revealed she did not recall what time she administered Resident #1 her PRN Tylenol but because it was a PRN medication, she would have had to put in a progress note. She revealed the medication administration record would not let you close the administration documentation out without putting in a progress note. LPN E revealed that she believed she had documented the administration of the Tylenol into the EMR. During an interview on [DATE] at 03:39p.m., LPN A revealed she did not administer Tylenol or any pain medication to Resident #1 on [DATE]. She revealed Resident #1 slept the morning, through the beginning of her shift and by lunch time, they had identified Resident #1's change of condition and initiated the process for sending her to the hospital. During an interview on [DATE] at 04:08 p.m., the ADON revealed if the MAR or TAR was blank, it meant the medication or task was not administered or done. 3. Record review of Resident #1's Order Recap Report, orders dated [DATE]- [DATE], reflected the order Skin Assessment to be completed weekly and PRN every day shift every Mon for skin skin [sic], start date [DATE], and an end date of [DATE]. Record review of Resident #1's [DATE]- [DATE] NMAR, dated [DATE], reflected Resident #1 was ordered Skin Assessment to be completed weekly and PRN every day shift every Mon for skin skin [sic], start date of [DATE] at 06:00 a.m., and an end date of [DATE] at 08:57 a.m. Resident #1 was documented as the Skin Assessment was Administered on [DATE] by RN C and on [DATE] by LPN A. Record review of Resident #1's EMR Assessment tab, undated and accessed on [DATE], did not reflect a SKIN ASSESSMENT - V 2 dated for the week of [DATE] or for the week of [DATE]. The most recent SKIN ASSESSMENT - V 2 was dated [DATE]. (continued on next page)

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Riverside Nursing and Rehabilitation Center	1555 Bandera Hwy Kerrville, TX 78028

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Progress Notes, dated [DATE] to [DATE] only revealed the following notes regarding Resident #1's skin status: - the Progress Note, dated [DATE] at 01:57 p.m. by the ADON, reflected .Resident has no visible signs of injury ., - the [EMR evaluation tool] SBAR Summary for Providers note, dated [DATE] at 12:54 p.m. by LPN A, reflected .Skin Status Evaluation: [blank] , and - the . Clinical Admission note, dated [DATE] at 05:49 p.m. by RN C, reflected .Skin : Skin warm & dry, skin color WNL and turgor [firmness of the skin] is normal. Record review of Resident #1's Witnessed Fall Incident Report, dated [DATE] at 03:00 a.m., reflected Resident #1 had No injuries observed at time of incident. No additional information on skin condition noted on the report. During an interview on [DATE] at 03:39 p.m., LPN A revealed the skin assessments would pop up on the nurses' screen as an order, but also as a UDA. She revealed that if the UDA populated on a different day than the order, the nurse would have to go in and switch the order to the day the skin assessment was done. She revealed that she might have marked in the MAR that the skin assessment had been done because it had already been done for that week. She revealed that if the UDA and order were on different days, it might cause the MAR to be off. Resident #1 was unavailable for observation or interview. Record review of Resident #1's Progress Note, dated [DATE] by LPN A, reflected Resident #1 had died and been pronounced by a hospice nurse on [DATE] at 08:53 a.m. 4. Record review of Resident #2's Admission Record, dated [DATE], reflected an [AGE] year-old female. She was admitted on [DATE]. Record review of Resident #2's Diagnosis Report, dated [DATE], reflected a principle diagnosis of Chronic Diastolic (Congestive) Heart Failure(a long-lasting condition resulting from the gradual decrease in the heart's ability to pump blood), a diagnosis of atherosclerotic heart disease (a buildup of fats in the arterial walls), and a diagnosis of type 2 diabetes Mellitus (a condition that develops with the way the body regulates and uses sugar as fuel). Record review of Resident #2's Quarterly MDS Assessment, dated [DATE] and signed as completed on [DATE] by the MDS Nurse and the DON, reflected assessment observation end date of [DATE]. Resident #2 had a BIMS score of 9 indicating she was moderately cognitively impaired. She required partial to moderate assistance to move to a standing position from sitting and to transfer from a bed to a chair, and she normally used a wheelchair. She was at risk of developing pressure ulcers/injuries, but did not have any pressure ulcers/injuries, venous or arterial ulcers, or other ulcers, wounds, or skin problems. Record review of Resident #2's Order Summary Report, active orders as of [DATE], reflected the order Skin Assessment to be completed weekly and PRN every day shift every Mon for skin skin [sic], order date of [DATE], start date of [DATE], and no end date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's [DATE]- [DATE], [DATE]- [DATE], and [DATE]- [DATE] NMARs, dated [DATE], reflected Resident #2 was ordered Skin Assessment to be completed weekly and PRN every day shift every Mon for skin skin [sic], start date of [DATE] at 06:00 a.m., and no end date. Resident #2 was documented as the Skin Assessment was Administered on [DATE] and [DATE] by RN C and on [DATE] by RN I. Record review of Resident #2's EMR Assessment tab, undated and accessed on [DATE], did not reflect a SKIN ASSESSMENT - V 2 dated for the week of [DATE], the week of [DATE], or for the week of [DATE]. Record review of Resident #2's Progress Notes, dated [DATE] to [DATE] did not reveal notes regarding Resident #2's skin status effective on the weeks of [DATE], [DATE], or [DATE]. During an interview on [DATE] at 01:57 p.m., Resident #2 revealed she felt safe at the facility, the staff assisted her if she needed anything, and the staff were very good at answering the call lights. She revealed she had not had any skin injuries or skin concerns since living at the facility. Attempted telephone interview on [DATE] at 03:31 p.m. with RN I. No call back received and staff member not present. During an interview on [DATE] at 04:18 p.m., RN C revealed skin assessments would come up on the MAR, notifying them, the nurse, that they needed to complete the skin assessment. She stated she might have completed the skin assessments for Resident #1 and Resident #2, but then forgotten to go back and enter her findings into the assessment screens. She revealed she typically would go in during a resident's shower to look over the resident's skin and then document her observations later on during the shift. During an interview on [DATE] at 04:08 p.m., the ADON revealed the facility used a skin assessment document and her expectation for the nurses was that they did the skin assessment. She revealed that the management team; herself, the DON, and the wound care nurse, would usually look at the assessments and the UDA to verify that the actual assessment was done. She revealed that if the MAR showed that the skin assessment was administered or checked, that would indicate that the nurse checked off that they had looked at the resident's skin. If it was checked off in the MAR but not in the assessments tab, it would mean that the nurse did not put the assessment in there. She revealed she did not believe the nurse not putting in the assessment would impact the resident's care. She revealed this was because the nurse could have completed the skin assessment and because there were most likely not any abnormalities, they did not enter a skin assessment without abnormalities or changes. During an interview on [DATE] at 04: 46 p.m., the DON revealed the nurses are supposed to complete a skin assessment weekly. She revealed the facility had a plan in place, which they had started the prior week, to monitor the weekly skin assessments. She revealed the nurses were expected to go into the EMR and chart yes they completed the skin assessment. She revealed the nurses were only to chart on the progress notes if there was anything wrong, but if it was blank, that meant there were no issues. She revealed that if the MAR for a skin assessment was checked as administered by a nurse , then that meant that they did it and if there was anything wrong, the nurse would have charted that. The DON revealed that she did not believe a documented completion of a skin assessment on the MAR without a corresponding skin assessment would have impacted the resident. She revealed the facility had a treatment nurse, who looked at all the resident's skin. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Pain- Clinical Protocol, dated revised [DATE] and February 2025, reflected: Under Assessment and Recognition 2. The nursing staff will assess each resident for pain .whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. Under Monitoring .1. The staff will reassess the resident's pain and related consequences at regular intervals; at least each shift for acute pain or significant changes in levels of chronic pain .Review should include frequency, duration and intensity of pain, ability to perform activities of daily living (ADLs), sleep pattern, mood, behavior, and participation in activities. 2. The staff will evaluate and report the resident's use of standing and PRN analgesics [a group of drugs used to achieve relieve from pain]. Record review of the facility's policy, Administering Pain Medications, dated revised [DATE], reflected: Under Purpose The purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. Under Steps in the Procedure 3. Conduct a pain assessment as indicated. The initial assessment is comprehensive and should follow the facility pain assessment procedure. 4. Conduct an abbreviated pain assessment if there has been no change in condition since the previous assessment. The assessment shall consist of at least the following components: a. Whether pain has improved or worsened since the last assessment; b. The general condition of the resident; c. Verbal and non-verbal signs of pain; d. Level of consciousness; and e. Evidence or reports of adverse consequences related to medications. 6. Administer pain medications as ordered. 9. Re-evaluate the resident's level of pain ,d+[DATE] minutes after administering. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under Documentation Document the following in the resident's medical record: 1. Results of the pain assessment; 2. Medication; 3. Dose; 4. Route of administration; and 5. Results of the medication (adverse or desired). A request for a facility policy on skin assessments was requested to the DON on [DATE] at 05:20 p.m. A copy of the facility policy, Resident Assessments was provided in its place. The Resident Assessments policy refers to the facility policies and procedures for comprehensive assessments and does not directly correlate with the weekly skin assessments.