STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. Building B. Wing	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsburg Nursing Center	123 Pecan Grove Pittsburg, TX 75686

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46310 Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with state law through established procedures for 1 of 16 residents (Resident #32) reviewed for abuse. The facility did not thoroughly investigate or report to the state survey agency when Resident #32 reported allegations of abuse of being slapped by a staff member. This failure could place the residents at risk for further potential abuse due to unreported and uninvestigated allegations of abuse, and neglect. Findings included: Record review of facility policy, Pittsburg Nursing Center Prevention and Reporting Suspected Resident Abuse and Neglect revealed The Administrator and Director of Nursing (DON) are responsible for investigation and reporting. Investigation of all alleged violations will be done under the direction of DON and/or Administrator. This may utilize the Complaint form, Initial Investigation for Possible Abuse Violations form, or other written documentation Record review of consolidated physician orders and face sheet dated 7/25/2022 through 8/25/2022 indicated Resident #32 was [AGE] years old, admitted on [DATE] with diagnoses of Alzheimer's disease, unspecified psychotic disorder with delusions due to unknown physiological condition, a progressive neurodegenerative condition, other specified depressive episodes, anxiety disorder, and cognitive communication deficit. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the most recent comprehensive MDS dated [DATE] indicated Resident #32 understands and was understood by others. The assessment indicated her BIMS score (a score indicating cognition) was 10 indicating cognitive impact. The assessment indicated she did have physical or verbal behaviors directed at others. The assessment indicated Resident #32 required partial/moderate assistance from staff with oral hygiene, toileting hygiene, shower/bathe self, and lower body dressing. The assessment indicated that Resident #32 required setup or clean-up assistance from staff with eating, upper body dressing, and putting on/taking off footwear. The assessment further indicated that Resident #32 required supervision or touching assistance from staff with sit to stand, chair/bed-to-chair transfer, and walker ten feet. The assessment indicated that Resident #32 was independent in roll left and right, sit to lying, and lying to sitting on side of bed. -se Record review of a care plan dated 8/18/2022 indicated Resident #32 had Cognitive loss/Dementia has s had a diagnosis of Unspecified Dementia with behavioral disturbances, Alzheimer's disease, Resident has long and short-term memory deficits, inattention and disorganized thinking that fluctuates. Resident can make needs known and had difficulty finding words/completing sentences. The goal for this focus is to continue to participate with activities of daily living, being clean, and appropriately dressed daily through next review. The approach for this focus is for resident to utilize call light, disregard in appropriate responses and comments, if resident is behaviors are affecting other residents, remove from common area and place in calmer setting. Do not isolate but provide music, TV or other appropriate activities. Staff will observe change in mental status or increased behaviors and report to physician. Care plans focus of psychosocial well-being indicated that resident has a new diagnosis of Bipolar, a manic depression, per psychiatric assessment completed on 4/27/21. PASSAR evaluation, completed upon entry, determined that resident does not meet criteria for services and returned from Solutions with diagnosis of Alzheimer's disease with behaviors, agitation, and paranoid/delusions. The goal indicated that needs will be met through next review date. The approach for this focus to assess reports of behaviors, asses for pain, and change in mental status. Explain reason/need for medication/care and risk due to refusal. Explain why behaviors are inappropriate and implement appropriate interventions as per the physician. If resident becomes aggressive, combative, or refuse care, provide safety, offer alternative times for care, back away, seek assistance as needed and notify nurse of behaviors and refusal. Record review of an incident and accidents log revealed no such incident was either reported or logged. The incidents and accidents log were reviewed for period of January 2022 through present date. The log was being reviewed to see if an incident related to this tag had been reported. Record review of in-service related to Abuse and Neglect, Employee Burnout, Confidentiality, Dignity, Privacy, and Advanced Directive, dated January 2022, revealed .the definitions of abuse, types of abuse, examples of verbal mental abuse, physical abuse, sexual abuse, and neglect. This document also listed definition and examples of involuntary seclusion and misappropriation of property. The document reveals reporting of abuse must be reported immediately. The facility only has 2 hours to report to the state Record review of statements completed by administrator and the DON and copy of the progress/nursing note from staff regarding what was reported to abuse coordinator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation with resident on 8/22/2022 at 9:44 a.m., Resident #32 said that she is just fine. She said that a staff member (does not know her name) has been put in jail for slapping her. She said that the staff member was in her room at the time and that staff from corporate could see it in [NAME]. She said that corporate fired her. She said that she is unsure why she hit her, but the idea that maybe she didn't like her. She said that other staff treat her well. She said that she has no complaints regarding other staff. Resident was observed with no visible marks or bruises on either side of her face. During an interview on 8/25/2022 at 12:21 p.m., the ADON indicated she was unaware of Resident #32 accusing a staff member of slapping her in the face. She said that Resident #32 is often confused, agitated, but she stays to herself most of the time. She said that she expresses she wants to go home but that is not possible for her. She said that she is aware of the process of reporting abuse or neglect. She said that the abuse coordinator is the Administrator and that she knows the number to contact state to make a report if she deemed it was necessary. During an interview on 8/25/2022 at 12:54 p.m., the DON indicated she was aware of Resident #32 accused someone of hitting her in the face. She said that Resident #32 has some days when she obsessed with a dog and her family son refusing to bring the dog to the facility. She said that Resident #32 wants to go home. She said that a charge nurse, LVN H, informed her about the accusation made my Resident #32. She said that the resident has told her that she has seen her mother and father in her TV and accused staff of sleeping with her son. She said that she recently accused a female staff of coming into her room and slapping her twice. The resident told the DON that the owner was present and that he filmed the entire incident. She said that she observed no marks or bruises on the resident's face. She said that the owner has not been present in the building since middle of July 2022. She said that the abuse coordinator is the administrator. She said the incident was not reported by her because she knows the resident to have Dementia with delusions and she does not believe anything occurred. She said that there was no staff member actually named by the resident and the charge nurse that initially told of her the accusation does not work over the weekends. She said that she is aware of the abuse policy, and she told the abuse coordinator, the Administrator, who conducted her own investigation, she assumed. She said that potential risks to residents for not following the abuse policy would be that any one of them could potentially be abused by staff. (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 8/25/2022 at 1:55 p.m., the Administrator said that she was informed of the accusation made by Resident #32 from both a charge nurse, LVN H, and the DON. The Administrator indicated she was the abuse coordinator and was responsible for reporting abuse. She said that she knows the process of reporting incidents of abuse and/or neglect. She said this incident was not reporting reported because she knows this did not happened and that she knows Resident #32. She said that it was not a valid accusation as she could not give a staff name and talked about the owner being present. She said that owner has not been int the building in over a month. She said that the DON interviewed the resident and that she did as well. She said that when she spoke with the resident, the resident told her that the nurse out there at the desk, slapped her over the weekend. She said that that particular staff does not work on weekends. She said the resident further accused the same staff of hanging out with her family member son at a nudist colony. She said the resident was observed by her and the DON during their interviews and there were no visible bruising or redness of any kind to any portion of her face. She said that the resident also told her that the owner came from [NAME] and videotaped the incident. She said that she did not report this because of the resident's diagnosis and the inconsistencies of the report. She said that the abuse policy does not indicate to not report if a resident has a diagnosis with delusional affects. She said that she just did not feel that this was reportable because it did not happen. She said that she has in-service with staff regularly to ensure they are familiar with the abuse policy. She said the risk of not reporting an allegation of abuse or neglect would place the residents in potential harm of being mistreated. During interview with CNA/Med Aide on 8/25/2022 at 11:12 AM, she said that she overheard Resident #32 telling the story to another resident. She said she did not ask her about the incident but that she informed the charge nurse of what she heard. She said that she did not get details and that the resident did not tell her anything about it. She said that she knows who the abuse coordinator is and that she told her about the accusations as well. She said that she knows how to file a report with the state herself is if something were to happen to any resident, she would first remove them from the situation and then make notification to everyone that is required to know. She said she would immediately intervene if she heard a staff speaking in an inappropriate manner and report them. During an interview with charge nurse, LVN H, on 8/25/2022 at 2:20 p.m., LVN H said that she was aware of the incident regarding Resident #32. She said that when she came in on one Monday morning, 8/15/2022, and during her rounds, Resident #32 said to her aren't you the bitch that slapped me. LVN said she told the resident that it was not her and that she did not and would not hit her. She said that she attempted to explain that she had just came back to work and that she does not work on the weekends. She said she asked the resident to elaborate, and the resident told her nigger get out of her, it was you. She said she could not redirect this behavior from the resident, and she notified the DON and the administrator. She said that she knows the abuse coordinator and she reported the incident to her. She said that she did not and would not hit a resident as she would not want to lose her license. She said that if she suspected abuse and it appears that nothing has changed, she would contact the ombudsman or make a report with state herself. She said that the resident told her that the staff member had already been arrested and was in jail. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with LVN on 8/25/2022 at 11:30 AM, she said that she is agency staff and is not present in the facility daily. She said has been back and forth the for about 8 months. She said that she has not had an in-service training related to abuse since being at the facility. She said that she does know that the abuse coordinator is the Administrator. She said that if she witnesses any inappropriate actions or conversation between staff and resident or resident and resident she would intervene and ensure the resident is safe. She said she would notify the DON and administration. She said that she knows how to makes report on her own to the state line if she deemed it necessary.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33249 Based on observations, record review and interview the facility failed to develop the baseline care plan within 48 hours of admission for 4 of 14 residents (Resident #'s 5, 91, 92 and 191) reviewed for baseline care plans. Resident #'s 5, 91, 92 and 191 did not have a base line care plan completed within 48 hours of admission. 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. Findings included: 1.Record review of a face sheet undated face sheet indicated Resident #5 was an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with diagnoses including cancer of the laryngeal cartilage (cancer of the voice box), cancer of the glottis (cancer of the vocal cords), absence of the larynx (absence of a voice box), high blood pressure, and dementia. Record review of the base line care plan indicated it was dated on 1/23/2021 on the prior admission. Record review of the care plan did not indicate a baseline care plan for the admission of 6/27/2022. The comprehensive care plan was dated 8/22/2022 for the problem areas of Full code, gastrostomy tube, memory and recall problem, high blood pressure, diabetes, and laryngectomy (removal of the larynx). Resident #5 was discharged home for 3 months then readmitted on [DATE]. 2.Record review of an undated face sheet indicated Resident #91 was a [AGE] year-old female who admitted on [DATE] with dementia, muscle wasting, depression, glaucoma, high blood pressure, and constipation. Record review of the baseline care plan indicated a created date of 8/23/2022. The comprehensive care plan was dated 8/22/2022 and included the problem areas of activities, a new nursing home, social isolation, glaucoma with a fall risk, self-care deficit, dehydration, depression, full code status, and malnutrition with weight changes. 3. Record review of an undated face sheet indicated Resident #92 was a [AGE] year-old male admitted on [DATE] with the diagnoses of stroke, left sided weakness, diabetes, anxiety, chronic kidney disease, and was a smoker. Record review of the base line care plan indicated the care plan was created on 8/23/2022. The comprehensive care plan indicated only the problem area of history of weight changes and malnutrition was created within the 48-hour time frame of a baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/24/2022 at 1:30 p.m., LVN H indicated she had been employed by the facility for two years and she indicated she was unsure where to find the baseline care plan, or who was responsible for creating the care plan. 4. During interview and observation with Resident #191 on 8/22/2022 at 10:16 a.m., he was resting in bed. He said that he felt fine but wanted to rest for now. During interview and observation with Resident #191 on 8/23/2022 at 10:57 a.m., he was asleep in bed. There were two fall matts were present during observation at his bedside. During interview and observation with Resident #191 on 8/24/2022 at 1:37 p.m., he said that he has only been at the facility for about a month maybe. He said that he has no concerns to share because he is still new here and does not know staff or residents by name. He said that when he pulls his call light it is answered by staff in a good amount of time. He said that he does not know what a care plan is and, but that staff do talk to him about what he needs. Record review of consolidated physician orders and face sheet dated 7/25/2022 through 8/25/2022 indicated Resident #191 was [AGE] years old, admitted on [DATE] with diagnosed with other fracture of left lower leg, subsequent encounter for closed fracture with routine healing (primary diagnosis for admission) bacterial infection, muscle wasting and atrophy, muscle weakness and mobility, and cognitive communication deficit. Record review of the most recent comprehensive MDS dated [DATE] indicated Resident #191 understands and was understood by others. The assessment indicated her BIMS score (a score indicating cognition) was 10 indicating cognitive impact. The assessment indicated his functional status supervision needed for locomotion on unit and eating. The assessment indicated that he required limited assistance with personal hygiene, toilet use, dressing, transfer and bed mobility. The assessment indicated that a full evaluation cannot be made as the tasks have only been completed once or twice in walk in room, walk in corridor, and locomotion off unit. Record review of an acute care plan dated 8/17/2022 indicated Resident #191 had activities of daily living functional/rehabilitation focus as the resident uses a wheelchair due to non-weight baring on left ankle fracture. The goal for this focus is the resident will have no injuries from use of chair through next review. The approach for this focus is to monitor changes and report physician, ensure cushion is in chair seat for use, assist resident with mobility as needed. During an interview on 8/25/2022 at 12:45 p.m., the ADON indicated the MDS nurse has always completed the baseline care plan. The ADON indicated the facility does not have a MDS person at present time. The ADON indicated she believed the corporate MDS nurse was completing the baseline care plans. During an interview on 8/25/2022 at 1:16 p.m., the DON indicated she was unaware of the base line care plan requiring 48 hours for completion. The DON indicated the base line care plan provides care needs for the resident. The DON indicated the resident could get hurt if the staff were unsure of the needs of the resident . The DON indicated she believed the corporate MDS nurse was completing the baseline care plans. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/25/2022 at 2:07 p.m., the Administrator indicated the MDS coordinator resigned her position. The Administrator indicated the previous MDS coordinator would make us aware of the need for the baseline care plan and the previous DON would complete the care plan. The Administrator indicated the previous DON passed away recently. The Administrator indicated the care plan tells the staff how to care for the resident and the resident could be injured if the staff were unsure of the care needed. Record review of a Baseline Plan of Care policy and procedure dated April 19, 2021, indicated a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission. 2. (g) The baseline care plan must include the instructions needed to provided effective and person-centered care of the resident that meet profession standards of quality of care and the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident -specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. 46310

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 14 residents reviewed for care plans. (Resident #142) The facility failed to develop a comprehensive person-centered care plan for skin ulcers for Resident #142. This failure could place residents at risk of not having individual needs met, a decreased quality of life, and delayed wound healing. Findings include: Record review of Resident #142's undated face sheet indicated that resident was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses pleural effusion (fluid between the lungs and chest), dementia, neuropathy (damage to nerves that impair sensation or movement), heart failure, and atrial fibrillation (rapid heart rate that causes poor blood flow). Record review of Resident #142's physician orders dated 07/25/2022-08/25/2022 indicated that resident had an order for: 1. Skin prep to bilateral feet every shift to prevent skin breakdown dated 08/11/2022 2. R distal, medial foot, right second toe, right third toe, left first toe, left second toe, left distal lateral foot, left fifth toe, left lateral ankle: Clean with normal saline and gauze, pat dry with gauze, apply hydrogel to each affected area, and apply ABD cover and wrap with kerlix roll once a day dated 08/23/2022. Record review of Resident #142's MDS dated [DATE] indicated that resident rarely/never able to make herself understood and rarely/never able to understand others related to moderately impaired cognition. Resident #142 was unable to complete a BIMS assessment. MDS also indicated that Resident #142 required extensive assist from 2 persons for bed mobility and transfers, and total assist dressing, toileting, and bathing. MDS also indicated Resident #142 had applications of dressings to feet (with or without topical medications). Section M of Resident #142's MDS assessment reflected that she had no skin issues or ulcers. Record review of Resident #142's care plan created 08/18/2022 indicated that Resident #142 was at risk for pressure ulcers related to impaired mobility with a goal for resident's skin to remain intact. and Resident #142 was experiencing selfcare deficit related to dementia with interventions for staff was to assist with dressing, AM and PM care as needed, and grooming needs. There was no care plan for noted dark colored areas to Resident #142's bilateral feet wounds. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #142's progress note dated 08/08/2022 at 17:45(5:45 PM) indicated that LVN A charted Skin w/d (warm and dry) to touch on upper extremities, cooler to touch on lower extremities dues to diabetic neuropathy with notable diabetic ulcers. Resident also has a stage 2 pressure ulcer (wound that is open through the second layer of skin) on coccyx and left buttock that is noted on admission observation skin assessment. Record review of Resident #142's admission observation dated 08/08/2022 at 17:45(5:45PM) completed by LVN A indicated that Resident #142 had a stage 2 pressure ulcer to her coccyx measuring 0.9 centimeters X 0.2 centimeters, a diabetic ulcer to her left second toe measuring 0.5 centimeters X 0.5 centimeters, and a stage 2 pressure ulcer to her left buttock measuring 0.1 centimeters X 0.1 centimeters. During an observation on 08/22/2022 at 9:45 AM Resident #142 was sitting on the side of her bed with her bare feet and noted black wounds to bilateral feet. With the way the resident was sitting, the right second, area medial to right first toe, left first toe, and left second toe were visible with no dressing in place. During an observation on 08/23/2022 at 10:15 AM with LVN C and NP D Resident #142 was being assessed by NP D for the first time. Resident had dark colored wounds to R distal, medial foot, right second toe, right third toe, left first toe, left second toe, left distal lateral foot, left fifth toe, and left lateral ankle. During an interview on 08/23/2022 at 10:43 AM with NP D he said that he was notified of Resident #142's wound to bilateral feet today and was in the facility for her initial assessment. During an interview on 08/23/2022 at 10:30 AM with LVN C he said that Resident had areas to bilateral feet upon admit and there was a treatment in place for skin prep to bilateral feet with no covering dressings. He said the facility was waiting on the NP D to come in for assessment and changes to orders. During an interview on 08/23/2022 at 1:10PM the DON said that nurses are expected to complete a full skin assessment when residents admit and document assessment. The DON said Resident #142 had blisters to bilateral feet upon admission and the order was to apply skin prep to bilateral feet areas. During an interview on 08/23/2022 at 2:00 PM with LVN A, she said that upon admission Resident #142 had 3-4 diabetic ulcers noted to both of her feet. LVN A said she normally does extensive documentation. She said the areas were not open and the order was placed for skin prep to bilateral feet. During an interview on 08/25/2022 at 12:58PM the DON said Resident #142 admitted on [DATE] and on 08/09/2022 she was notified that resident had a pencil sized open area to her left buttocks and blisters to her bilateral feet. The DON said she performed an undocumented assessment on Resident #142 on 08/09/2022 and received the order for skin prep to bilateral feet. The DON said each area to the feet should have had a separate order but if she was doing the treatment, she would apply skip prep all of the wounds of both feet. The DON said the areas should have been care planned because without a care plan, other nurses would not know what to do or how to treat the resident wounds. She said the corporate MDS nurse has been responsible for completing care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/25/2022 at 1:48PM the Administrator said she expected nursing to have care plans in place for all residents. The MDS Corporate nurse was responsible for inputting care plans because they did not have a MDS nurse at that time. She said without the care plan staff could miss what is going on with the residents. Record review of the Care Planning-Interdisciplinary Team policy dated April 19,2021 indicated Policy: The facility's Care Planning Interdisciplinary Team is responsible for the development of individualized comprehensive care plan for each resident. Procedure: 1. A comprehensive care plan for each resident is developed within 7 days of completion of the resident assessment (MDS). 2. The care plan is based on the resident's comprehensive assessment.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsburg Nursing Center	123 Pecan Grove Pittsburg, TX 75686

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interview, observation, and record review, the facility failed to ensure the residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 resident (Resident #142) of 14 residents reviewed for quality of care. The facility failed to notify the physician and obtain treatment orders when skin issues were identified on Resident #142's bilateral feet upon admission. These failures could place residents at risk of receiving inadequate care. Findings included: Record review of Resident #142's undated face sheet indicated that resident was an 86year old female who admitted to the facility on [DATE] with the diagnoses pleural effusion (fluid between the lungs and chest), dementia, neuropathy neuropathy (damage to nerves that impair sensation or movement), heart failure, and atrial fibrillation (rapid heart rate that causes poor blood flow). Record review of Resident #142's MDS dated [DATE] indicated that resident rarely/never able to make herself understood and rarely/never able to understand others related to moderately impaired cognition. Resident #142 was unable to complete a BIMS assessment. MDS also indicated that Resident #142 required extensive assist from 2 persons for bed mobility and transfers, and total assist dressing, toileting, and bathing. MDS also indicated Resident #142 had applications of dressings to feet (with or without topical medications). Section M of Resident #142's MDS assessment reflected that she had no skin issues or ulcers. Record review of Resident #142's care plan created 08/18/2022 indicated that Resident #142 was at risk for pressure ulcers related to impaired mobility with a goal for resident's skin to remain intact. and Resident #142 was experiencing selfcare deficit related to dementia with interventions for staff was to assist with dressing, AM and PM care as needed, and grooming needs. There was no care plan for noted dark colored areas to Resident #142's bilateral feet wounds. Record review of Resident #142's progress note date 08/08/2022 at 17:45(5:45 PM) indicated that LVN A charted Skin w/d (warm and dry) to touch on upper extremities, cooler to touch on lower extremities dues to diabetic neuropathy with notable diabetic ulcers. Resident also has a stage 2 on coccyx and left buttock that is noted on admission observation skin assessment. Record review of Resident #142's admission observation dated 08/08/2022 at 17:45(5:45PM) completed by LVN A indicated that Resident #142 had a stage 2 pressure ulcer to her coccyx measuring 0.9 centimeters X 0.2 centimeters, a diabetic ulcer to her left second toe measuring 0.5 centimeters X 0.5 centimeters, and a stage 2 pressure ulcer to her left buttock measuring 0.1 centimeters X 0.1 centimeters. Record review of Resident #142's physician orders dated 07/25/2022-08/25/2022 indicated that resident had an order for: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Skin prep to bilateral feet every shift to prevent skin breakdown dated 08/11/2022 2. R distal, medial foot, right second toe, right third toe, left first toe, left second toe, left distal lateral foot, left fifth toe, left lateral ankle: Clean with normal saline and gauze, pat dry with gauze, apply hydrogel to each affected area, and apply ABD cover and wrap with kerlix roll once a day dated 08/23/2022. 3. There was no order noted for coccyx or left buttock. Record review of a Resident #142's Initial wound evaluation and management summary dated 08/23/2022, signed by NP D, indicated a skin tear wound of right distal, medial foot full thickness that measured 2cmX3cmX0.1cm with moderate serous exudate (drainage), 10%necrotic tissue (dead black tissue), 10%slough (dead yellow skin sliding off), and 80% granulation. Record review of a Resident #142's Initial wound evaluation and management summary dated 08/23/2022, signed by NP D, indicated a skin tear wound of right, second toe partial thickness that measured 0.9cmX1.5cmXunmeasureable depth Record review of a Resident #142's Initial wound evaluation and management summary dated 08/23/2022, signed by NP D, indicated a skin tear wound of right, third toe partial thickness that measured 1cmX1cmXunmeasureable depth Record review of a Resident #142's Initial wound evaluation and management summary dated 08/23/2022, signed by NP D, indicated a skin tear wound of left, first toe partial thickness that measured 0.5cmX1cmXunmeasureable depth Record review of a Resident #142's Initial wound evaluation and management summary dated 08/23/2022, signed by NP D, indicated a skin tear wound to left, second toe partial thickness that measured 0.8cmX1Xunmeasureable depth Record review of a Resident #142's Initial wound evaluation and management summary dated 08/23/2022, signed by NP D, indicated a skin tear wound to left, distal, lateral foot partial thickness that measured 0.6cmX0.6cmXunmeasureable depth Record review of a Resident #142's Initial wound evaluation and management summary dated 08/23/2022, signed by NP D, indicated a skin tear of the left, fifth toe partial thickness that measured 0.5cmX0.5cmunmeasureble depth Record review of a Resident #142's Initial wound evaluation and management summary dated 08/23/2022, signed by NP D, indicated a skin tear wound of the left, lateral ankle partial thickness that measured 0.5cmX0.5cmunmeasureble depth During an interview on 08/23/2022 at 10:30 AM with LVN C he said that Resident had areas to bilateral feet upon admit and there was a treatment in place for skin prep (a liquid forming dressing) to bilateral feet. He said the facility was waiting on the NP D to come in for assessment and changes to orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/23/2022 at 10:43 AM with NP D said the facility had just notified him by phone of the wounds to Resident #142's bilateral feet and the need for assessment on 08/23/2022. During an interview on 08/23/2022 at 1:10PM the DON said that nurses are expected to complete a full skin assessment when residents admit, document assessment, and notify the Facility MD of any abnormal findings. The DON said Resident #142 had blisters to bilateral feet upon admission and the order was to apply skin prep to bilateral feet areas. During an interview on 08/23/2022 at 2:00 PM with LVN A, she said that upon admission Resident #142 had 3-4 diabetic ulcers noted to both of her feet. LVN A said she normally does extensive documentation. She said the areas were not open and the order was placed for skin prep to bilateral feet. During a telephone interview on 08/23/2022 at 2:25 PM the Facility MD, which was Resident #142's physician, said that the facility staff normally called him about issues when they came about, but Resident #142 did not have any areas to her bilateral feet that he was aware of. He said he was in the facility on 08/22/2022 and no one in the facility notified him about anything for Resident #142. He said he would be planning on visiting Resident #142 for an assessment. During an interview on 08/24/22 at 12:01 PM with CNA F she said that she had been working in the facility since 2019. CNA F said when Resident #142 admitted to the facility there were blisters to both of her feet. She said the nurses were placing skin prep on them but no dressings. CNA F said the areas to Resident #142's feet were not open when she came. She said that she knew when working with any resident, if anything new is noticed she was supposed to call the nurses to the room to look at the areas found. During an interview and observation on 08/24/22 at 2:31 PM with the Facility MD he said was here to assess Resident #142. LVN E removed the dressings for the MD to look at Resident #142's feet. The Facility MD assessed Resident #142 head to toe and said that Resident #142 has no pulses (meaning decreased circulation and causes wounds not to heal) to her bilateral feet and will need to be referred to a vascular doctor and the wounds that exist to bilateral feet are not skin tears, they are vascular ulcers. During an interview on 08/25/2022 at 12:58PM the DON said that she was responsible for ensuring assessments and follow up was completed for new admissions. The DON said she looked at completeness of the assessments but did not read them to the entirety. The DON said Resident #142 admitted on [DATE] and on 08/09/2022 she was notified that resident had a pencil sized open area to her left buttocks and blisters to her bilateral feet. The DON said she assessed Resident #142 and received the order for skin prep to bilateral feet. The DON said she knew that each area to Resident #142's feet should have had a separate order but if she was doing the treatment, she would have placed skin prep on all areas of both feet. She said the Facility MD should have been called, the family, and information placed on the 24-hour report sheet. The DON said the areas should have been care planned because without a care plan, other nurses would not know what to do or how to treat resident wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/25/2022 at 1:48PM the Administrator said she expected nursing to have care plans in place for all residents. She said when the skin areas were noted, the charge nurse should have notified the DON and ADON, called the MD for treatment orders, and called the family. She said when skin issues were found they should have been reported on the 24-hour report log to notify other staff. The Administrator said that without care plans in place the staff could miss care for residents. Record review of the undated policy for Wound Care indicated: Purpose The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation 1. Verify that there is a physician's order in place for this procedure. 2. Review the reident's care plan to assess for any special needs of the resident . Reporting 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facilty policy and professional standards of practice.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care consistent with professional standards of practice for 1 of 14 (Resident # 5) reviewed for respiratory care. The facility did not ensure Resident #5 had replacement laryngectomy supplies (laryngectomy replacement tube) in the facility or at the bedside and a bag valve mask (handheld device used to provide rescue breaths during cardiac pulmonary resuscitation) at the bedside. This failure resulted in an identification of an Immediate Jeopardy (IJ) at 2:27 p.m. on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of respiratory infection, respiratory distress and respiratory failure. Findings included: 1.Record review of an undated face sheet indicated Resident #5 was an [AGE] year-old male, admitted to the facility on [DATE] with the diagnoses including malignant neoplasm of the laryngeal cartilage (cancer of the voice box), absence of larynx (no voice box), Chronic obstructive lung disease (group of lung diseases that block airflow), and malignant neoplasm of glottis (cancer of the true vocal cords). Record review of the consolidated physician orders dated [DATE] indicated Resident #5 had orders to suction each shift, laryngectomy tube care every morning, and cleanse stoma area with normal saline and pat dry each shift. Record review of the MDS dated [DATE] indicated Resident #5 usually understands and was usually understood. Resident #5's BIMS score was an 11 indicating moderate cognitive impairment. Resident #5 requires extensive assistance of one staff for bed mobility, dressing, toilet use, and personal hygiene. Resident #5 requires extensive assistance of two staff for transfers and total assistance of one staff with bathing. The MDS section other Major Surgery was marked involving the endocrine organs, neck, lymph nodes or thymus. Section O of the MDS indicated Resident #5 required suctioning over the last 14 days. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the care plan dated [DATE] indicated Resident #5 had a laryngectomy and had a laryngectomy tube with a goal of no symptoms of infection around the stoma (airway opening) or any signs of respiratory distress. The care plan interventions for Resident #5 included clean or replace neck straps if the old one was dirty, nursing would monitor and assess the skin around the stoma for redness, drainage and signs of warmth, clean the stoma with normal saline pat dry and re-insert, clean laryngectomy tube with water and mild soap, monitor oxygen saturation, monitor for symptoms of infection around the stoma, nursing to ensure a suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at bedside at all times. During an observation and interview on initial tour on [DATE] at 10:45 a.m., Resident #5 was sitting in his wheelchair in his room. There was a suction machine sitting at bedside. There were no visible replacement tubes or oxygen available in the room . During an interview with LVN H she indicated there were no replacement tubes in the facility. LVN H indicated there was no oxygen nor a bag valve mask (mask with a bag used for rescue breathing) at bedside. LVN H indicated Resident #5's family had an extra replacement laryngectomy tube at home, but he had the replacement tube in use now. LVN H indicated the facility did not have the replacement tubes because of the expense she was told. LVN H indicated in an emergency she would have to call 911. On [DATE] at 11:30 a.m., a call and a message was placed to the Nurse Practitioner at his office with no return phone call received regarding Resident #5's laryngectomy tube and care needed. During a telephone interview on [DATE] at 11:35 a.m., the physician indicated Resident #5 was at risk to lose his airway due to a mucus plug. The physician indicated he expected Resident #5's airway to be maintained via the larygectomy tube using an AMBU bag until EMS could arrive. The physician indicated the facility did not have the training to sustain Resident #5's airway by using another airway sustaining device such as an endotracheal tube (a tube placed directly in the tracheal). During an interview on [DATE] at 11:40 a.m., the Administrator indicated the facility had no replacement tubes or emergency supplies but had suction at bedside. The Administrator indicated if anything went wrong with Resident #5, they would call EMS. During an interview on [DATE] at 11:42 a.m., the Regional Nurse, indicated it was not procedural to have a bag valve mask at bedside for Resident #5 . During an interview on [DATE] at 11:45 a.m., the DON indicated the laryngeal tube was to keep Resident #5's airway open. The DON indicated she was unsure why the facility had not purchased any replacement laryngeal tubes. During an interview on [DATE] at 11:50 a.m., the ADON indicated hopefully the extra laryngeal tube will arrive tomorrow [DATE]. The ADON indicated she believed the Administrator found a laryngeal tube in Dallas. During an interview on [DATE] at 12:50 p.m., LVN H indicated the NP wanted a tracheostomy kit at bedside and oxygen with humidification for Resident #5. Record review of a nursing note dated [DATE] indicated the NP ordered oxygen at ,d+[DATE] liters via nasal cannula if oxygen was below 90%, a concentrator at bedside along with bag mask, tracheostomy kit, and suction for Resident #5. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of in-services conducted in 2022 indicated there were no in-services provided to the staff related to Resident #5's laryngeal tube. The facility did conduct an in-service regarding respiratory training on [DATE] but the material did not reveal any in-service material on laryngectomy tubes or laryngectomy care. During an interview on [DATE] at 1:39 p.m., LVN H indicated if she activated EMS for Resident #5 it would take EMS ,d+[DATE] minutes to arrive and it would take 5 more minutes to get the local hospital. LVN H indicated if she had to administer rescue breathing (breaths supplied by a mask and bag) for Resident #5, she would apply the mask to his mouth and provide ventilation until EMS could get him out of the facility. During an interview on [DATE] at 1:44 p.m., the DON indicated the EMS response time would be 3 minutes and then another 3 minutes to the local emergency room . The DON indicated she would use the mask valve for respirations on the stoma site itself. The DON indicated the excess air would come out of Resident #5's mouth. The DON indicated the respiratory training in on [DATE] did not include laryngectomy training and the training was only verbal. The DON indicated no computer-based training or use of a manikin. During an interview on [DATE] at 1:47 p.m., LVN C indicated for rescue breathing for Resident #5 he would close his stoma off and perform regular cardiopulmonary resuscitation. LVN C indicated the laryngeal tube does not affect his breathing. LVN C indicated he had not cared for a laryngeal tube before now. The administrator was notified of [DATE] at 2:27 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The administrator was provided the Immediate Jeopardy template and a Plan of Removal was requested. During an interview on [DATE] at 8:45 a.m., the Administrator indicated the laryngeal replacement tube arrived last night and was in the resident's room. The facility's Plan of Removal was accepted on [DATE] at 10:29 a.m. and included: Summary: The facility failed to have the appropriate emergency supplies at bedside: a replacement laryngectomy tube, and an artificial manual breathing unit (Ambu) bag for 1 of 1 resident with a laryngeal tube. The facility failed to train staff and ensure staff competency for laryngectomy tube care. Issues: *The facility failed to have the appropriate supplies at bedside : a replacement laryngeal tube and an artificial manual breathing unit (Ambu) bag. *The facility failed to train staff and ensure staff competency for laryngectomy tube care. Immediate Actions: 1.The resident's physician and responsible party were notified by the Director on Nursing on [DATE]. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All nurses were trained on appropriate laryngectomy tube care by the Director of Clinical Services on [DATE]. Ambu bag was placed at Resident #5's bedside on [DATE] An extra laryngectomy tube was obtained and placed at bedside at 9:30 p.m. on [DATE]. Plan was put in place until extra laryngectomy tube arrived as follows: *If tube comes out, clean and replace the tube. *If tube was unable to be replaced call 911. *While waiting on EMS (emergency medical services) to arrive: support the airway by monitoring secretions, suctioning as needed and monitoring oxygen saturations and completing a lung assessment. Provide supplemental oxygen with humidification as needed. 2.Education (provided by DON or ADON) *All nurses were in-serviced on appropriate laryngectomy tube care on [DATE]. This in-service includes competency checks by return demonstration. Each nurse will be in-serviced prior to return to shift. This will be completed by [DATE]. Nursing will not return to shift without the in-service and return demonstration. *All nurses were in-serviced on emergency procedures related to Cardiopulmonary Resuscitation of a person with a laryngectomy tube on [DATE] which includes appropriate placement of the Ambu (mask valve bag ventilation) over the laryngectomy to create a good seal. This in-service will be completed by [DATE]. *All nurses were in-serviced on items that need to be kept at bedside for a resident with a laryngectomy tube beginning [DATE] which includes Ambu bag and replacement laryngectomy tube. This in-service will be completed by [DATE]. Nursing will not return to shift without the in-service. *All nurses were in-serviced on what to do if laryngectomy tube was unable to be replaced on [DATE]. This in-service included: if tube comes out, clean and replace the tube. Additionally, if tube was unable to be replaced Call 911. Then, while waiting on EMS to arrive: Support the airway by monitoring secretions, suctioning as needed and monitoring oxygen saturation and completing a lung assessment, and supplemental oxygen with humidification as needed. This in-service will be completed by [DATE]. Nursing will not return to shift without the in-services. 3. The Medical Director had been notified of the Immediate Jeopardy. 4. An interim QAPI committee meeting was completed on [DATE]. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on [DATE] at 8:25 a.m., Resident #5 was lying in his bed. The emergency care supplies and equipment including a tracheostomy kit, suction, Ambu bag, extra laryngeal tube, and oxygen. The suction machine and Ambu bag were sitting on a bedside table at the head of Resident #5's bed. The oxygen concentrator was stored in the room and the extra laryngeal tube was pinned under the overbed light at the head of Resident #5's bed. On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to the Immediate Jeopardy (IJ) by: Interviews of the nursing staff (ADON; DON; 2 nurses on the 6:00 a.m.-2:00 p.m.; 3 agency nurses working various remove shifts; 1 nurse working 2:00 p.m. -10:00; and 2 nurses on the 10:00 p.m. -6:00 a.m.) were performed. During these interviews nurses stated correctly how to support Resident #5's airway until EMS arrived, and what items were needed at bedside to support Resident #5's airway. On [DATE] at 3:11 p.m., the Administrator was informed the IJ was removed: however, the facility remained out of compliance at a severity level of potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. Laryngectomy | Tracheostomy Education, accessed on [DATE] A total laryngectomy is typically performed when the disease cannot be managed with more conservative measures. In a total laryngectomy the entire larynx is removed (including the vocal folds, hyoid bone, epiglottis, thyroid and cricoid cartilage and a few tracheal cartilage rings). The airway is separated from the nose, mouth and esophagus. The trachea is brought forward below the level of the larynx and is sutured to the base of the neck just above the sternal notch, creating a permanent opening in the neck called a stoma. Therefore, the individual does not breathe through the upper airway. Instead, breathing occurs through the stoma. Breathing, speech, and swallowing are significantly changed after the procedure. Since the stoma is the only passageway for breathing, it is important to maintain the airway and suction the trachea through the stoma as needed, using a sterile technique. It is also important to clean the stoma, as crusting of secretions may develop that can block or occlude the stoma. It is important to teach the patient, family and/or caregivers how to care for the stoma properly, and what to do in case of an emergency. A laryngectomy is a procedure which alters the anatomy of the upper airway and results in breathing that occurs only through the stoma. The entire larynx is removed during a total laryngectomy. In tracheostomy, the upper airway is still intact. There is potential upper airway in patients with tracheostomy. Record review of an undated Laryngectomy Tube Care policy indicated the purpose of this procedure was to guide laryngectomy care. General Guidelines included: laryngectomy tubes should be changed as ordered and as needed, laryngectomy care should be provided as often as needed, at least once daily, a suction machine, supply of suction catheters, exam and sterile gloves, and flush solution must be available at the bedside at all times. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	rescue-breathing.pdf (d1a743corqz1mw.cloudfront.net) accessed on [DATE] Laryngectomees and other neck breathers are at great risk of getting inadequate acute care when they experience breathing difficulties or need cardiopulmonary resuscitation. It is essential that medical personnel learn to identify neck breathers and differentiate partial neck breathers from total neck breathers. Respiratory problems unique to neck breathers are mucus plugs, and foreign body aspiration. Although partial neck breathers inhale and exhale mainly through their stoma they still have a connection between their lungs, and their nose, and mouth. In contrast there is no such connection in total neck breathers. Both partial and total neck breathers should be ventilated through their tracheostomy site. However, the mouth needs to be closed and the nose sealed in partial neck breathers to prevent air escape. An infant or toddler bag valve mask should be used in ventilating through the stoma. Laryngectomees and other neck breathers are at great risk of getting inadequate acute care when they experience breathing difficulties or need cardiopulmonary resuscitation (CPR)1. Many of emergency department (ED) and emergency response services (EMS) personnel do not recognize a patient who is a neck breather, do not know how to administer oxygen to them in the proper way, and may erroneously give mouth-to-mouth breathing when mouth-to-stoma breathing is indicated. This can lead to devastating consequences because it can deprive sick people from the oxygen, they need to survive2. Prepare for Rescue Breathing The steps in rescuing a neck breather are to first determine their unresponsiveness; then activate the emergency medical services; position the person raising their shoulders; expose the neck and remove anything covering the stoma (filter, cloth) that may prevent access to the airway; secure the airway by checking the neck for a stoma, remove anything that blocks the airways such as the filter or HME if present; and clear any mucous from the stoma. It is not necessary to remove the stoma's housing unless it blocks the airway. In emergency situations, laryngectomy tubes and stoma buttons may be removed carefully if they are blocking the airway. The voice prosthesis should not be removed unless it is blocking the airway. The voice prosthesis generally does not interfere with breathing or suctioning. If the prosthesis is dislodged it should be removed and replaced with a catheter to prevent aspiration and fistula closure. If present the tracheal tube may need to be suctioned after insertion of , d+[DATE] cc of sterile saline or removed (outer & inner) to clear any plugs. The stoma should be wiped and suctioned. The next step is to listen for breathing sounds over the stoma. The chest may fail to rise because the tracheostomy tube is blocked. If a tracheostomy tube is used for resuscitation, it should be shorter than the regular one so that it can fit the length of the trachea. Care should be used in inserting the tube so that it does not dislodge the voice prosthesis (see Figure 9). This may require the use of a tube with a smaller diameter Ventilation in neck breathers: The actual rescue breathing for neck breathers is generally similar to the one performed on normal individual with one major exception. In neck breathers ventilation and oxygen administration is done through the stoma (mouth to stoma, Figure 9 - left) or using a mask (infant/toddler or adult turned through 900, Figure 9 - right). It is useless to try mouth-to-mouth ventilation. The website https://pubmed.ncbi.nlm.nih.gov/20520261/ accessed on [DATE] stated .respiratory infections can result from the use of medical devices and respiratory supplies. These devices can contribute to the home care or hospice patient developing a respiratory infection by serving as a reservoir and supporting the growth of microorganisms and by directly infecting patients when this equipment becomes contaminated . Oxygen Therapy: Concentrator. The external filter on the concentrator should be washed with soap and water, air dried, and replaced on the oxygen concentrator minimally on a weekly basis . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	45810

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46310 Based on observations, interviews and record review, the facility failed attempt to use appropriate alternatives prior to installing a side or bed rail. The facility failed to assess the resident for risk of entrapment from bed rails prior to installation, failed to review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation and failed to ensure that the bed's dimensions were appropriate for the resident's size and weight, in accordance with State law through established procedures for 1 of 16 resident (Resident # 3) reviewed for bedrails. The facility failed to assess the Resident #3 for risk of entrapment from bed rails prior to installation. This failure could place the residents at risk for entrapment, injury, or harm. Findings included: During interview and observation with Resident #3 on 8/22/2022 at 10:38 a.m., she said that she feels okay but that her foot is hurting. She had a bandage on her right foot, and she also had a bandage on her left leg. She said that she has delayed polio syndrome and is a diabetic, so she has some ulcers on her foot. She said that her leg was scratched being transferred from the wheelchair one day. She said that when she pulls her call light they come as often as they can. She said they seem to be short staffed sometimes as nursing staff are always busy and on the go. She said that she does not feel restricted by bed rails as they are low, and they help her to position herself. She said that she came with the bed from home and that the Administrator spoke with her family member upon entry regarding the use, but she is not sure about the details. She said that staff aid her in transfer from her bed to wheelchair, so she is not restricted by the bedrails in any way. During an interview on 8/25/2022 at 12:21 p.m., the ADON indicated she was unaware a resident needed to have an assessment to use the side rails on their bed. She said that she has been the ADON for 6 years and that she has never completed an assessment for bed rails. She said that some of the residents came from home with their bed. She said that she cannot recall in every completing an assessment for any resident with side rails. She said an assessment for this would have needed to be done during admission or whenever it is ordered by the physician. She said that they are required to obtain orders and add to care plan if this changes, but she hasn't ever completed an assessment. She said that she was not aware that consent had to be given for the use of bedrails. She said they are the risk of harm to residents is that they could become injured, entrapped, and restrained. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/25/2022 at 12:54 p.m., the DON indicated she was aware of Resident #3 having side rails on her bed. She said that they are being used to aid her in positioning herself in bed. She said she has only been the DON for about two months. She said that she was not aware that an assessment had to be completed on side rails since they are not full rails. She said that she is aware that some residents have bed rails. She said that she obtained consent from Resident #3's family member and she completed the assessment. She said that she will have an in-service training for all other nursing staff. She said that assessments will now be completed during admission if the resident has a bed that he or she would like to bring into the facility or when a change occurs. She said that any nursing staff on duty can perform the assessment as she will provide in-service training on this soon to all staff. The DON did not give a specific date or time for this training. She said staff already ensure that the care plan is updated to reflect the orders for side rails. She said that the risk was injury, entrapment, or restrained without knowing how to utilize the bed. During an interview on 8/25/2022 at 1:55 p.m., the Administrator said that some residents have half rail assist bars on their beds and she was not aware that those required an assessment since they are not fully restrictive. She said that she will require that an assessment be completed during admission if resident brings a bed from home. She said that they already obtain orders and care plan the rails. She said that she and the DON discussed completing in-service on side rails assessment, this week. She said that if the bed had full bed rails, it was the expectation that an assessment be completed but one has not been done to her knowledge. She said that she has not given the ADON or DON a timeframe to ensure that the full facility is trained to complete an assessment regarding bedrails. She said that she is aware that Resident #3 uses her side rails for mobility and repositioning in bed. She said that the resident does not feel safe in bed without the rails even with the fall matt. She said that the assessment when would ensure that the resident is aware of how to use them, enable the facility to staff to know their use for the resident, and the consent associated with the assessment will ensure that responsible party understands the risk. She said that the risk for not having completed and assessment prior to now is that the resident could have been entrapped or injured without staff knowledge. Record review of consolidated physician orders and face sheet dated 7/25/2022 through 8/25/2022 indicated Resident #3 was [AGE] years old, admitted on [DATE] with diagnosed with Encephalopathy (unspecified) as primary diagnosis, R55 syncope and collapse, facture of unspecified part of the neck of right femur, subsequent encounter of closed facture with routine healing. Other diagnoses are post-polio syndrome, other lack of coordination left upper arm, and other abnormalities of gait and mobility. Record review of the most recent comprehensive MDS dated [DATE] indicated Resident #3 understands and was understood by others. The assessment indicated her BIMS score (a score indicating cognition) was 14 indicating cognitive intact. The assessment indicated his functional status supervision needed for locomotion on unit, locomotion off unit, and eating. The assessment indicated that he required excessive assistance with bed mobility, transfer, personal hygiene, toilet use, and dressing. The assessment indicated that these tasks did not occur to be evaluated; walk in room and walk in corridor. Orders indicated that on 1/18/2020, with no end date, enabler bars to both sides of bed to assist with bed mobility and turning and repositioning. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an acute care plan dated 6/22/2022 indicated Resident #3 uses enabler bar on both side of her bed to assist with bed mobility, turning, and repositioning in bed. The goal for this focus is that resident will have no injuries from enabler bar through next review date. The intervention for focus is to apply enabler bars as ordered, if residents hit arm or head on bars notify nurse, monitor ability to use enabler bar safety, monitor portion of upper extremities and head while assisting with bed mobility and notify physician if any changes. Record review of facility policy on Proper Use of Side Rails dated 6/2020 .an assessment will be made to determine if the resident's symptoms, risk to entrapment, and reason for using side rails. When used for mobility or transfer, an assessment will be included a review of the resident's bed mobility, ability to change positions, transfer to and from bed to chair, and to stand and toilet. Risk of entrapment from the use of side rails, and that the bed's dimensions are appropriate for the resident's size and weight. The use of side rails as an assistive device will be addressed in the resident's care plan, and consent for using restrictive devices will be obtained from the resident's or legal representative per facility protocol . Record review of Side rail assessment and consent dated 8/24/22 and signed by representative on 8/25/22 revealed the reason for side rails is for bed mobility, Only top half rails on both sides are to be used .

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on interview and record review, the facility failed to ensure residents were seen by the physician for the initial visit for 1 of 14 residents (Resident #'s 5) reviewed for physician visit The facility did not ensure Resident #'s 5 received an initial comprehensive assessment by their physician. This deficient practice could place newly admitted residents at risk of not having their physician visit initially and could lead to a decline in health status or untreated conditions. The findings included: Record review of Resident #5's undated face sheet indicated he was an [AGE] year-old male admitted to the facility on [DATE] with a primary payor source as Medicare Part A. Resident #5's diagnoses included cancer of the larynx (voice box), absence of the larynx (voice box), muscle wasting, abnormal weight loss, difficulty swallowing, and high blood pressure. Record review of the Admission MDS indicated Resident #5's MDS assessment was also a 5-day Medicare Part A assessment. The MDS indicated Resident #5 was usually understood and understands. Resident #5's BIMS score was an 11 indicating moderate impairment of his cognition. Resident #5 required extensive assistance of one staff for bed mobility, dressing, toilet use, and personal hygiene. He required extensive assistance with transfers by two staff members and total assistance of one staff with bathing. The MDS indicated his primary medical condition was considered medically complex condition with the diagnoses of the malignant neoplasm of the laryngeal cartilage (cancer of the voice box). The MDS indicated Resident #5 received speech therapy, occupational therapy, and physical therapy. Record review of a soap (subjective, objective, assessment, and plan) note dated 7/26/2022 indicated Resident #5 was seen by the NP and the NP electronically signed the note. The encounter note indicated Resident #5 was seen for a new patient evaluation to establish care with physician present during rounds. The encounter note indicated Resident #5's primary payor source was Medicare. The note in the section of plan does not address his laryngectomy. During an interview on 8/24/2022 at 12:02 p.m., the NP indicated he was unaware the physician had to complete the initial evaluation and note for the Part A Medicare residents. He indicated he had been told differently. During an interview on 8/24/2022 at 12:32 p.m., the physician indicated he was unaware he had to complete the initial evaluation assessment and document the assessment. During an interview on 8/25/2022 at 12:45 p.m., the ADON indicated the NP and the physician make rounds together. She indicated she was aware of all the initial encounter notes were completed by the NP. The ADON indicated there was no monitoring system of the performed physician visits . The ADON indicated she was unaware the physician had to complete the assessment and note per the regulations. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/25/2022 at 1:16 p.m., the DON indicated she was unaware of the physician not completing his initial evaluation notes. The DON indicated a risk could be the two practitioners may not agree on the findings. The DON indicated she had never known a NP to complete a history and physical or initial evaluation. During an interview on 8/25/2022 the Administrator indicated she was not aware the physician initial evaluation notes indicate the NP completes the initial assessment and signs the assessment. The Administrator indicated she was responsible and indicated there was no monitoring system in place. Record review of a Physician Services policy dated 5/2017 indicated the policy statement was the medical care of each resident was under the supervision of a licensed physician . 3. The physician will perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 33249 Based on interview, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility reviewed for RN coverage. The facility failed to provide RN coverage for 8 consecutive hours daily on 6-26-22, 8-6-22,8-7-22, 8-13-22, 8-14-22 and 8-21-22. This deficient practice had the potential to affect residents in the facility by leaving staff without supervisory coverage for RN-specific nursing activities and for coordination of events such as emergency care and disasters. Findings include: Record review of the facility's last 3 months (June, July and August) of time sheets for RN coverage revealed that the facility did not have an RN in the facility on 6-26-22, 8-6-22,8-7-22, 8-13-22, 8-14-22 and 8-21-22. During an interview on 8/25/22 at 12:45 p.m., the ADON indicated they had only one RN on an as needed basis but were actively trying to hire a RN. The ADON also indicated the previous weekend RN had changed to an as needed basis and had not worked for over a month. They ADON indicated that they could request for agency but had not. The ADON stated the DON was transitioning into her new role and had been aware of the staffing issues. During an interview on 8/25/22 at 1:16 p.m., the DON indicated there was currently an ad on Indeed (job posting site) for a weekend RN but she had not had a chance to review the applicants . The DON indicated there was no other RN but me. The DON also indicated agency staff could be used for the eight hours of RN coverage. During an interview on 8/25/22 at 2:07 p.m., the Administrator indicated the facility was actively trying to find an RN. The Administrator indicated since the death of the previous DON, and the resignation of the weekend RN it had been hard to cover weekend RN position. The Administrator indicated the use agency was an option. The Administrator also indicated that the current DON was always available for calls when not in the facility. The Administrator indicated there was no risk the DON was available at all times for oversight. Record review of an undated nurse staffing requirements policy indicated the requirement for long-term care facilities provide 24-hour licensed nursing, provide a Registered Nurse (RN) for eight (8) consecutive hours a day, seven (7) days a week, and a RN designated as Director of Nursing on a full-time basis.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure that its medication error rates were not 5 percent or greater. There were 3 errors out of 46 opportunities, resulting in a 6.52 percent medication error rate involving 2 out of 8 residents reviewed for medication errors. (Resident #'s 31 and 39) MA L failed to hold the administration of Coreg 3.125 milligrams one tablet twice daily with the parameters of hold for systolic blood pressure less than 110 for Resident #31. Resident #31's blood pressure was 108/61. MA L failed to administer 2 spironolactone 100 milligrams to equal 200 mg for Resident #39. MA L failed to hold the administration of Midodrine 10 milligrams when Resident #39's blood pressure was 124/84 with a holding parameter of hold for systolic blood pressure greater than 120 and diastolic blood pressure greater than 80. This failure could place residents at risk of not receiving the therapeutic outcomes and possible negative outcomes. Findings included: 1. Record review of an undated face sheet indicated Resident #31 was [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia, high blood pressure, and stroke. Record review of a Significant Change MDS dated [DATE] indicated Resident #31 was understood and understands. Resident #31's BIMs score was 11 moderate cognitive impairment. The MDS indicated Resident #31 required extensive assistance with bed mobility, locomotion, and personal hygiene. She required total assistance with dressing, toilet use and bathing. The MDS under Section I Active Diagnoses high blood pressure was marked. Record review of Resident #31's comprehensive care plan does not address high blood pressure. Record review of a physician's order dated 4/01/2019 indicated Resident #31 had ordered Coreg 3/125 milligrams one tablet twice daily with meals for high blood pressure. The order had parameters to hold if systolic blood pressure was less than 110. During an observation on 8/24/2022 at 9:30 a.m., MA L obtained Resident #31's blood pressure. The blood pressure results were 108/61 with a heart rate of 73. Resident #31 was administered Coreg 3.125 milligrams one tablet by mouth by MA L. The Coreg was administered after the breakfast meal. 2. Record review of an undated face sheet indicated Resident #39 was a [AGE] year-old female admitted on [DATE] with the diagnoses of alcoholic liver disease (liver failure related to alcohol use), anxiety, and anemia. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Significant Change MDS dated [DATE] indicated Resident #39 was understood and understands. The MDS indicated Resident #39 had a BIMs score of 10 indicating moderate cognitive impairment. The MDS indicated Resident #39 required set up help only for bed mobility, transfers, walking, locomotion, dressing, eating, toilet use. Resident #39 required the assistance of one staff for personal hygiene and bathing. The MDS under the Section N0410 Medications Received indicated Resident #39 received diuretics over the last 7 days. Record review of a comprehensive care plan dated 4/19/2022 indicated Resident #39 had a diagnosis of low blood pressure and takes Midodrine. Check blood pressure as ordered and notify the medical doctor of abnormal results was the intervention and hold the medication per parameters given by the medical doctor. The comprehensive care plan included Resident #39 had a potential fluid deficit related to the use of diuretics including spironolactone for alcoholic liver disease with the intervention of monitor vital signs as ordered or per protocol and notify the medical doctor with abnormal findings. Record review of the consolidated physician's orders dated 7/25/2022 -8/25/2022 indicated Resident #39 had an order for midodrine 10 milligrams one tablet by mouth daily with parameters of systolic blood pressure greater than 120 or diastolic blood pressure greater than 80. Resident #39 had an order for spironolactone 100 mg two by mouth daily. During an observation on 8/23/2022 at 11:27 a.m., MA L assessed the blood pressure of Resident #39 the results were 124/84 and a heart rate of 99. MA L administered Midodrine 10 milligram one by mouth and Spironolactone 100 mg one tablet by mouth. During an interview on 8/24/2022 at 11:45 p.m., MA L indicated she was in a hurry because the medications were becoming late administrations. MA L indicated by administering the medications outside the parameters and by the inaccurate dosing she could have hurt the resident. During an interview on 8/25/2022 at 12:45 p.m., the ADON indicated with blood pressure medications administered outside of the parameters could cause the blood pressure to drop lower. The ADON was not sure how the Midodrine worked but indicated the outcome would not be good. The ADON indicated with the diuretic dosage error the resident could experience fluid overload. During an interview on 8/25/2022 at 1:16 p.m., the DON indicated administration of the Coreg outside the parameters could cause the blood pressure to drop and the resident could experience the need for resuscitation. The DON indicated administering Midodrine outside the parameters could cause a residents blood pressure to go too high causing cardiac issues. The DON indicated administration of spironolactone inaccurately could cause a resident to experience fluid overload. The DON indicated the pharmacist does medication passes with the nurses and medication aides to monitor compliance with medication pass but since becoming the DON she had not seen this completed. During an interview on 8/25/2022 at 2:07 p.m., the Administrator indicated she expected the medications to be administered according to the physician's orders. The Administrator indicated the DON was responsible for ensuring skills check offs were completed for the medication aides and nurses. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Administering Medications policy dated 5/2022 indicated medications shall be administered in a safe and timely manner and as prescribed. 8. The individual administering the medication must check the label three ties to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 45810 Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, the expiration date when applicable and stored all drugs and biologicals in locked compartments for 3 (Resident #19, #29, #35) of 14 residents reviewed for medication storage. The facility did not ensure Resident #35's Preparation H hemorrhoid suppository was not kept at bedside. The facility did not ensure Resident #19's Admelog Solostar insulin was dated when opened. The facility did not ensure Resident #29's Basaglar Kwikpen insulin was dated when opened. This failure could place residents at risk of not receiving the therapeutic benefit of medications, adverse reactions to medications, or harm by ingestion. 1.Record review of Resident #35's undated face sheet indicated that resident was a [AGE] year old female who admitted to the facility of [DATE] with diagnoses osteoarthritis (disease that causes wearing down of cartilage between bones), diabetes with hyperglycemia (high blood sugar), schizoaffective disorder (mental disorder), and high blood pressure. Record review of Resident #35's Physician order report dated from [DATE]-[DATE] indicated that resident had an order for: 1. May use generic equivalents unless otherwise stated 2. Preparation H (phenyleleph-min oil-petrolatum) (OTC) ointment; 0.25mg-,d+[DATE].9%; amt; application; rectal for [dx unspecified hemorrhoids] as needed Record review of Resident #35's MDS dated [DATE] indicated that resident had a BIMS score of 12 which indicated resident has some mild cognitive impairment. MDS also indicated that Resident #35 required supervision from 1 person with bed mobility, transfers, toileting, and total assist from one person with bathing. Record review of Resident #35's care plan edited [DATE] indicated that resident had a problem of cognitive loss with a goal for resident to continue participating in activities of daily living . and an approach to include provide medications as ordered . (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 observation on [DATE] at 12:44 PM Resident #35 was in her room sitting in her wheelchair and had a hemorrhoid suppository in a silver wrap with expiration date of ,d+[DATE] sitting on her bedside dresser. During an observation on [DATE] at 8:47 AM Resident #35 continued to have a hemorrhoid suppository on her bedside dresser. During an observation and interview on [DATE] at 2:08 PM CNA G was said she made up Resident #35's bed and cleaned her room, but she did not see the suppository sitting on the bedside dresser. She said she knows residents should not have medications in the rooms and if she had seen it, she would have taken it to the nurse to notify. During an interview on [DATE] at 2:20 PM LVN E said she was not aware of any resident who was allowed to have medication at the bedside. She said she would get medication and discard it. She said all medications should be locked in the medication room or the carts. LVN E said this failure could place Resident #35 or other resident at risk of ingesting medication. 2. Record review of an undated face sheet indicated Resident #19 was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with the diagnoses of diabetes, anemia, chronic pain, and malnutrition. Record review of an Annual MDS dated [DATE] indicated Resident #19 understands and was understood. The MDS indicated Resident #19's BIMS score was a 14 indicating cognitively intact. Resident #19 required supervision with her ADLs. Under Section N0350 of the MDS the facility coded the use of insulin injections 7 days of the last 7 days. Record review of a comprehensive care plan dated [DATE] indicated Resident #19 had diabetes and was at risk for adverse reactions to Admelog with the interventions of monitoring for signs of high and low sugar levels. Record review of the consolidated physician orders indicated on [DATE] Resident #19 was ordered Admelog Solostar U-100 insulin 10 units before meals and hold for blood sugars less than 120. During an observation and interview on [DATE] at 9:40 a.m., Resident #19 had Admelog insulin on the medication cart opened and undated. LVN H indicated the nurse who opens the medication should date the medication when opened. LVN H indicated the insulin could be less effective due to being expired after open for 30 days. 3. Record review of an updated face sheet indicated Resident #29 was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with the diagnoses of morbid obesity and diabetes. Record review of an Annual MDS dated [DATE] indicated Resident #29 understands and was understood. Resident #29's BIMs score was 12 indicating mild impairment. The MDS indicated Resident #29 required extensive assistance with bed mobility, personal hygiene, and dressing. He required total assistance with transfers, toileting, and bathing. The MDS under the Section N0350 the facility coded 7 days of the last 7 days he received insulin injections. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the consolidated physician orders dated [DATE] indicated Resident #29 had an order for Basaglar Kwikpen U-100 Insulin administer 60 units every morning. Record review of a comprehensive care plan dated [DATE] indicated Resident #29 had diabetes with the interventions to monitor for high and low blood sugar levels. During an observation and interview of [DATE] at 9:54 a.m., Resident #29's Basaglar insulin was opened and undated on the medication cart. LVN C indicated the nurse was responsible for ensuring the insulin was dated when opened. LVN C indicated the insulin was good after being opened 21 or 27 days. LVN C indicated he did not have an excuse why the insulin was not dated. LVN C indicated negative outcomes could happen from not dating opened insulin. During an interview on [DATE] at 12:45 p.m., the ADON indicated insulin should be dated when opened. She indicated the insulin could be on the cart too long and could have negative side effects or not work properly. During an interview on [DATE] at 1:16 p.m., the DON indicated insulin should be dated when opened. The insulin should be discarded in 28 days from the date opened. The DON indicated the insulin loses its effectiveness and could not lower the blood sugar as desired. The DON indicated she was responsible for monitoring the insulins. During an interview on [DATE] at 2:07 p.m., the Administrator indicated she expected the insulin to be dated when opened. The Administrator indicated the insulin was not good after a certain amount of time and could adversely affect the resident. The Administrator indicated the administrative nurses were responsible for monitoring. Record review of an Administering Medications policy dated ,d+[DATE] indicated medications shall be administered in a safe and timely manner, and as prescribed.9. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. Record review of the Storage of Medications policy dated ,d+[DATE] indicated Policy Statement The facility shall store drugs and biologicals in a safe, secure, and orderly manner Policy Interpretation and Implementation 1. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems they are received .2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, sanitary manner .10. Only persons authorized to prepare and administer medications shall have access to the medication room, including keys. Admelog: Uses, Side Effects, Warnings - Drugs.com accessed on [DATE] Storing opened (in use) Admelog: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Store the vial in a refrigerator until the expiration date on the pen or vial, or at room temperature and use within 28 days. Store the SoloStar injection pen (without a needle attached) at room temperature and use within 28 days. https://uspl.lilly.com/basaglar/basaglar accessed on [DATE] In-use Pen Store the Pen you are currently using at room temperature [up to 86 F (30 C)] and away from heat and light. Throw away the Pen you are using after 28 days, even if it still has insulin left in it. During an interview on [DATE] at 12:20 PM the ADON said that all residents in the facility should be given medications by a nurse or medication aid. She said no medications should be kept in resident's rooms but be kept locked in carts or med room. The ADON said medications being left at bedside could allow any resident to pick it up and take them. During an interview on [DATE] at 1:01 PM with the DON, she said that residents should have all medications kept in nursing carts and med room. The DON said this failure could put residents at risk for ingestion by any resident or cause the medications to be improperly used. During an interview on [DATE] at 1:55 PM The Administrator said that no resident's medications should be stored in rooms. She said all medications should be locked in a cart or the medication room. The administrator said this failure could place the residents at risk of getting the wrong medication, and that everyone is responsible for making sure no medications are in rooms.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33249 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. The facility failed to discard meatballs with a tomato sauce dated 8/15/2022. The facility failed to date opened canned diced tomatoes stored in the refrigerator. The facility failed to ensure the kitchen ceiling was clean and free from a brown colored material blowing from the air conditioning vent. This failure could place the residents at risk for food borne illnesses. Findings included: During initial tour of the facility's kitchen conducted on 8/22/2022 at between 8:59 a.m. -9:16 a.m. revealed: *Stored in a refrigerator a plastic storage container of meatballs with tomato sauce was dated 8/15/2022 *Stored in a refrigerator was an undated stainless-steel pan of canned diced tomatoes *The ceiling behind the cooking stove and the clean dish rack had brown colored material resembling lint was blowing from the air conditioning vent During an interview on 8/22/2022 at 9:13 a.m., the DM indicated the foods should be discarded after 2-3 days of storage. The DM indicated all foods opened and stored must be dated before going in the refrigerator. The DM indicated she was responsible for ensuring food was discarded and dated to prevent potentially hazardous foods from getting served to the residents. The DM indicated the ceiling dust was too high for her to reach. The DM indicated she could not climb on a latter and clean the ceiling. The DM indicated the Maintenance person was aware of the dirty ceiling. During an interview on 8/25/2022 at 1:16 p.m., the DON indicated she would be worried dust material could fall into the food and the improperly stored foods could cause gastric issues and possibly food poison. The DON indicated she relied on the DM ensured food safety. During an interview on 8/25/2022 at 2:07 p.m., the Administrator indicated she expected the foods in the refrigerators to be labeled and dated. The Administrator indicated the 8/15/2022 was the use by date on the meatballs with tomato sauce. The Administrator indicated the DM was responsible to ensure food safety to prevent potentially causing the residents to become sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated Storage of Food in Refrigeration indicated 4. All containers must be labeled with the contents and date food item was placed in storage. 5. Previously cooked foods can be held in refrigeration of 41 degrees Fahrenheit or lower for up to 7 days and then must be discarded. Record review of an undated Dietary Cleaning policy indicated did not address cleaning of the air conditioning vent or the ceiling of the kitchen . 2. Surfaces must be cleaned with sanitizing agent/solutions. Chlorine, iodine, or quaternary ammonium compounds were approved sanitizing agents.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on record review and interview, the facility failed to ensure the facility assessment was reviewed and updated as necessary, in that: The facility did not update their facility assessment when they admitted Resident #5 with a history of laryngeal cancer who had a laryngectomy (surgical removal of the larynx (voice box), affecting processes like breathing, swallowing, and speaking. This deficient practice could affect the resident by not having the necessary resources to ensure appropriate care is provided. Findings included: Record review of the facility assessment revealed it was dated as 1/10/2022. The Section 1.3 Diseases/Conditions, physical and cognitive disabilities did not reveal the disease of laryngeal cancer. The Section 1.4 Decision regarding caring for the residents with condition not listed above indicated the facility may accept persons that have diagnoses or conditions that they were not more familiar with and had not previously supported. If the facility had the opportunity to admit a person with a new diagnosis, they would thoroughly review the medical condition and in-service all staff on aspects and care of the condition or symptom, if we had the resources. Under the section of Special Treatments and Conditions Respiratory did not indicate a laryngectomy. In the Section 3.8 Resources the facility did not indicate they had laryngectomy tubes available. Record review of an undated face sheet indicated Resident #5 was an [AGE] year-old male, admitted to the facility on [DATE] with the diagnoses including malignant neoplasm of the laryngeal cartilage (cancer of the voice box), absence of larynx (no voice box), Chronic obstructive lung disease (group of lung diseases that block airflow), and malignant neoplasm of glottis (cancer of the true vocal cords). Record review of the consolidated physician orders dated 6/28/22 indicated Resident #5 had orders to suction each shift, laryngectomy tube care every morning, and cleanse stoma area with normal saline and pat dry each shift. Record review of the MDS dated [DATE] indicated Resident #5 usually understands and was usually understood. Resident #5's BIMS score was an 11 indicating moderate cognitive impairment. Resident #5 requires extensive assistance of one staff for bed mobility, dressing, toilet use, and personal hygiene. Resident #5 requires extensive assistance of two staff for transfers and total assistance of one staff with bathing. The MDS section other Major Surgery was marked involving the endocrine organs, neck, lymph nodes or thymus. Section O of the MDS indicated Resident #5 required suctioning over the last 14 days. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the care plan dated 8/22/22 indicated Resident #5 had a laryngectomy and had a laryngectomy tube with a goal of no symptoms of infection around the stoma (airway opening) or any signs of respiratory distress. The care plan interventions for Resident #5 included clean or replace neck straps if the old one was dirty, nursing would monitor and assess the skin around the stoma for redness, drainage and signs of warmth, clean the stoma with normal saline pat dry and re-insert, clean laryngectomy tube with water and mild soap, monitor oxygen saturation, monitor for symptoms of infection around the stoma, nursing to ensure a suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at bedside at all times. During an interview on 8/25/2022 at 12:45 p.m., the ADON indicated she was unfamiliar with the facility assessment. After surveyor explained the facility assessment, she indicated a laryngectomy should be on the assessment tool. The ADON indicated the Administrator was responsible for the facility assessment tool. During an interview on 8/25/2022 at 1:16 p.m., the DON indicated she was unaware of the facility assessment use or who was responsible for completing the assessment. The DON indicated she has been the DON for only 2 months. She indicated the previous DON accepted Resident #5 for admission to the facility. The DON indicating she as a floor nurse had expressed the need for education to the previous DON concerning the need for education regarding Resident #5's laryngectomy care. During an interview on 8/25/2022 at 2:07 p.m., the Administrator indicated she was unaware of needing to update the facility assessment as needed to reflect changes in the care and services the facility provides. The Administrator indicated the facility assessment would have no impact on the residents of the facility . The Administrator indicated she was responsible for the facility assessment. Record review of an undated Facility Assessment policy indicated the nursing facility would conduct, document, and annually review a facility-wide assessment, which includes their resident population and the resources the facility needs to care for their residents. The purpose of the assessment was to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. Use of this assessment to make decision about direct care staff needs, as well as capabilities to provide services to the resident in the facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being.

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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** 45810 Based on observation, interview, and record review the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 14 residents (Resident #4 and Resident #142) reviewed for infection control. LVN H failed to change gloves, wash hands, or sanitize before, during and after providing wound care to Resident #4's stage four wound to sacrum. LVN C failed to perform hand hygiene or change gloves before, during, and after providing wound care to Resident #142. These failures could place residents at risk for being exposed to health complications and infectious diseases. Findings included: Record review of the undated Infection Control policy indicated Handwashing 12.05 Purpose: Hand washing will be regarded by this facility as the single most important means of preventing the spread of infections. Procedure: 1. All personnel will follow the facility's established handwashing procedures to prevent the spread of infections. 2. Hands should be washed 20 (20) seconds under the following conditions: a. When coming on duty .c. before performing invasive procedures .e. before handling clean or soiled dressings, gauze pads, etc. f. after handling used dressings, contaminated equipment, etc. l. whenever in doubt. M. upon completion of duty. 1.Record review of Resident #142's undated face sheet indicated that resident was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses pleural effusion (fluid between the lungs and chest), dementia, neuropathy, heart failure, and atrial fibrillation (rapid heart rate that causes poor blood flow). Record review of Resident #142's MDS dated [DATE] indicated that resident rarely/never able to make herself understood and rarely/never able to understand others related to moderately impaired cognition. Resident #142 was unable to complete a BIMS assessment. MDS also indicated that Resident #142 required extensive assist from 2 persons for bed mobility and transfers, and total assist dressing, toileting, and bathing. MDS also indicated Resident #142 had applications of dressings to feet (with or without topical medications). (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 #142's care plan created 08/18/2022 indicated that Resident #142 was at risk for pressure ulcers related to impaired mobility and Resident #142 was experiencing selfcare deficit related to dementia with interventions for staff was to assist with dressing, AM and PM care as needed, and grooming needs. There was no care plan for noted dark colored wounds to Resident #142's bilateral feet. During an observation on 08/22/2022 at 10:15 AM, LVN C exited Resident #142's room with gloves on, sorted through the supplies in the bottom drawer of the nurse's cart to find supplies. LVN C walked up the hallway to speak to the DON about some supplies with gloves on. He then checked a treatment cart located at the nurse's station and removed gloves. LVN C returned to Resident #142's room and put gloves on his hand with no handwashing nor sanitizing performed. LVN C assisted NP D with transferring Resident #142 from her wheelchair to the bed. LVN C removed gloves and retrieved wax paper and supplies from the nursing cart and placed them on the bedside table. LVN C left the room. During an observation on 08/22/2022 at 10:35 AM, LVN C entered Resident # 142's room and placed cotton tipped swabs on the bedside table, then he put gloves on without handwashing or sanitizing hands. LVN C rolled Resident #142 to her right side for NP D to assess buttocks. When completed, LVN C removed his gloves and went into the bathroom to wash his hands. During an observation on 08/22/2022 at 10:44 AM, LVN C put on gloves and setup bedside table with wax paper covering the table. He then opened 4X4 gauze and placed on the wax paper, placed hydrogel (wound dressing liquid) into 2 medicine cups for use, a container of normal saline opened for use, kerlix wraps, and cotton tipped applicators all placed on wax paper. LVN C then closed Resident #142's door. LVN C removed gloves and put clean gloves on with no hand sanitizing nor handwashing performed. LVN C cleaned the wound to Resident #142's left first toe, left second toe, left distal lateral foot, left fifth toe, and left lateral ankle with clean normal saline soaked gauze. LVN C did not change gloves. LVN C then applied hydrogel with a clean cotton tipped applicator each to left first toe, left second toe, left distal lateral foot, left fifth toe, and left lateral ankle. He then covered areas with clean gauze and removed his gloves. LVN C labeled the tape for the kerlix wrapped dressings. LVN C put on new gloves and wrapped left foot with the kerlix and taped. During an observation on 08/22/2022 at 10:54 AM LVN C changed his gloves with no handwashing or sanitizing performed and cleaned Resident #142's R distal, medial foot, right second toe, and right third toe with normal saline soaked gauze. He then applied hydrogel with a cotton tipped applicator to Resident #142's R distal, medial foot, right second toe, and right third toe with the same gloves on. LVN C covered each area with clean gauze, wrapped with kerlix and then removed his gloves. LVN C labeled his tape and placed on kerlix. He then removed put new gloves on to gather all of the trash and placed in a red bag and tied the red bag. LVN C removed his gloves and discarded bag and did not wash hands or use hand sanitizer. LVN C used hand sanitizer from the cart in the hallway after exiting resident's room. During an interview on 08/22/2022 at 11:05 AM LVN C said he knew he performed the wound care in a horrible way. He said he did not sanitize his hands between clean and dirty and did not wash his hands as he knew he should have because Resident #142's wheelchair was in front of the doorway to the bathroom. He said his failure to wash his hands of sanitize could cause infection and no bug control (control of infections). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #4's face sheet, revealed a [AGE] year-old female who was admitted on [DATE] and then readmitted to the facility on [DATE]. She had diagnosis of chronic obstructive pulmonary disease with acute exacerbation (lung disease that block air flow and makes it difficult to breathe), dementia (memory loss), heart failure, pressure ulcer of sacral region. Record review of Resident #4's quarterly MDS dated [DATE], indicated Resident #4 was usually understood and usually understands. BIMS (Brief Interview for Mental Status) score was a 08 indicating moderately impaired cognition. The MDS indicated the resident required extensive assistance of two person for personal hygiene, toilet use, bed mobility, dressing and locomotion on unit. The MDS also indicated resident was at risk for developing pressure ulcers and had one stage four pressure ulcer present on admission. Record review of Resident #4's consolidated physician orders, revealed an order dated 5/10/22 indicating cleanse sacrum wound with normal saline, pat dry, apply collagen powder, calcium alginate with silver, and cover with hydrocolloid dressing three times weekly Record review of Resident #4's comprehensive care plan dated 3/19/22 indicated Resident #4 had a stage four wound to the sacrum and was at risk for infections, pain and or discomfort. The goal of the care plan indicated the wound would show signs of healing or heal without complications. The care plan interventions included wound care physician to evaluate weekly, fortified meals, wound care per physician orders, health shakes twice a day, low air loss mattress, reposition every two hours and as needed. During an observation and interview dated 8/23/22 at 9:13 AM LVN H provided wound care to Resident #4. LVN H applied gloves and failed to perform hand hygiene prior to putting on gloves. LVN H then proceeded to take off dressing to sacrum. LVN H failed to remove gloves and perform hand hygiene after removing the dirty dressing. LVN H then cleansed wound with normal saline and gauze. She then applied collagen powder to wound bed using wooden applicator. LVN H opened calcium alginate package and applied calcium alginate dressing to wound bed. LVN H then opened Duoderm dressing and applied dressing to wound, without any glove changes or hand hygiene. LVN H then took pen out of scrub pocket and dated dressing. LVN H removed gloves and she reapplied new gloves without performing hand hygiene. LVN H trash and supplies from the room and then removed her gloves. She failed to perform hand hygiene after completion of wound care. During an interview with LVN H she stated she did not know she needed to wash her hands in front of surveyor. LVN H indicated an infection could occur from not washing, sanitizing hands, or changing gloves when providing wound care. Record review of employee licensed nurse skills check off for wound treatment administration revealed LVN H was checked off on 3/29/22 with the skill being met. During an interview on 8/25/22 at 10:06 AM with LVN H, she indicated wound check offs were completed with the DON and the corporate nurse by demonstration. During an interview on 08/25/2022 at 12:18 PM the ADON said she expected the charge nurses to perform wound care the correct way. ADON said nurses are checked off for competency by the DON. She said they should change gloves and wash hands between clean and dirty. The ADON said if they do not it could cause infection issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. Building B. Wing	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsburg Nursing Center	123 Pecan Grove Pittsburg, TX 75686

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/25/2022 at 12:52 PM the DON said that nurses are checked off for competency including wound care upon hire and annually or as needed. She said the ADON is responsible upon hire to check off and the DON is responsible for the annual check offs for competency. The DON said she would expect a nurse to wash hands before putting gloves on and changing gloves. She said gloves should be changed if soiled or after dirty dressing removed, then clean gloves should be put on. The DON said if the nurses are not hand washing or sanitizing there could be a risk of more bacteria being introduced to the wound bed. Record review of the licensed nurse wound treatment administration skills review completed by The DON indicated that LVN C was checked off on 07/11/2022 but does not show if skills were met or unmet. 46928