STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455565	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 46062 Based on observation, interview, and record review the facility failed to ensure the resident had a right to a dignified existence, self-determination, and failed to ensure that the resident could exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility for 10 (Resident #34, #49, and 8 anonymous residents) of the 21 residents reviewed for resident rights. The facility failed to provide privacy while providing care for Resident #34. The facility failed to take Resident #49 to scheduled smoke breaks because they did not want to immediately put him back to bed afterwards. Ten residents in a confidential resident group interview said they are not able to exercise their resident rights. These failures could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings included: 1. Record review of a face sheet dated 8/1/22 revealed Resident #34 was [AGE] years old, male that admitted to the facility on [DATE] with the diagnoses of multiple sclerosis (nerve damage that disrupts the communication between the brain and the body), acute and chronic respiratory failure (difficulty breathing and the lungs do not get enough oxygen), hypertension (high blood pressure), pneumonia (infection that inflames the air sacs in the lungs and may be filled with fluid or pus), malnutrition (the body does not get enough nutrients), Stage 4 pressure ulcer (wound caused by pressure that has loss of tissue and exposed muscle or bone), and a history of coronavirus 2019. Record review of an admission MDS dated [DATE] indicated Resident #34 was unable to perform the BIMS. Resident #34 was total dependent and required the assistance of two persons for all ADLs. Resident #34 was always incontinent (unable to control) of bowels. Resident #34 was unable to communicate with others. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/01/22 at 5:22 PM, LVN W and TCNA V performed a linen change to the Resident #34's bed, followed by changing the gauze sponges around Resident #34's tracheostomy (direct airway opening by surgical incision into the trachea (windpipe)), then performed wound care to four different wounds and left Resident #34 uncovered and his body naked and fully exposed from his head to his toes for twenty minutes without providing privacy as much as possible. At the end of the procedures, LVN W went to obtain additional dressings for wound care and TCNA was holding Resident #34 on his right side. Resident #34 had a loose bowel movement and TCNA V laughed out loud. During an interview on 8/4/22 at 6:04 PM with TCNA V, she said staff should close the door or pull the curtain when providing care to residents. She said Resident #34 probably felt embarrassed and cold when herself and LVN W were providing care to the resident and left him uncovered for the duration of the procedures. She said she should have covered Resident #34 and then only uncovered the areas the nurse needed to perform care to. She said she did not mean to laugh at Resident #34 when he had another bowel movement after herself and LVN W had provided incontinent care and changed his bed. She said she had bad anxiety and laughed at inappropriate times and having a surveyor in the room made her nervous. She said her laughing when Resident #34 had a bowel movement probably made him feel embarrassed. 2. During a confidential resident group meeting on 8/2/22 at 10:02 a.m., Ten residents were in attendance and all 10 residents wished to remain anonymous. Anonymous Resident 8 said staff left her in a wet brief all day and it made her very embarrassed. AR8 said by the end of the day when she was finally changed, she smelled so bad in made her gag and eyes water. AR8 said if you asked to be put back to bed to be changed, then staff would not get you back up. AR8 said she was told the facility did not have enough staff to get her up and down multiple times a day. AR2, AR3, AR5, AR7, and AR9 said they did not feel they were treated with dignity and respect. AR5 said she has been woken in the middle of the night around 11:30 p.m. to get a shower because that was the only time the CNA was free to give her a shower. AR5 said she would have preferred her shower before she fell asleep. AR3 and AR5 said CNAs walk into their rooms without knocking which they did not like. AR5 and AR 7 said on the weekend, staff take up to 2 hours to answer call lights and it happens on a regular basis. All residents in the confidential resident group meeting said the facility did not review the resident rights and was unsure of their rights. 3. Record review of the consolidated physician orders revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis, need assistance with personal care, and muscle wasting and atrophy (shortening). Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance to total dependence for ADLs. The MDS revealed Resident #49 was a tobacco user. Record review of the undated care plan revealed Resident #49 was a smoker. Intervention included the need to wear a smoking apron. During an observation on 8/1/22 at 9:00 AM, a group of residents waiting to smoke were at the back door. Resident #49 was not in the group. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/2/22 at 3:15 PM, a group of residents were outside smoking and Resident #49 was not in the group. During an interview on 8/2/22 at 10:00 PM, Resident #49 said he was out of snuff and the person who used to buy it for him does not anymore. He said, I would really like to smoke a cigarette, but no one will get me up. He said staff do not want to get him up to smoke because he needs to be put back to bed soon afterwards. He said he cannot sit up for long periods of time because of his back issues. He said he has been a smoker for half of his life, and it sucked he could not do it now. During an interview on 8/3/22 at 10:37 AM, CNA N said Resident #49 was a smoker, but he wanted staff to immediately put him back to be afterwards. She said due to lack of staffing, she could not accommodate him. During an observation on 8/3/22 at 11:00 AM, a group of residents were outside smoking and Resident #49 was not in the group. During an observation on 8/4/22 at 7:00 PM, a group of residents were outside smoking and Resident #49 was not in the group. During an interview on 8/4/22 at 5:40 PM, the DON said it was not right for Resident #49 to be denied smoke breaks because staff did not want to put him back to bed. She said it infringed on his right to smoke. She said Resident #49 being denied his smoke breaks could cause depression because he cannot do something he likes. She said he already had depression issues because of his loss of independence. During an interview on 8/4/22 at 6:30 PM, the Administrator said not allowing Resident #49 to smoke due to lack of staffing was not an excuse. She said Resident #49 had the right to smoke and to be assisted out of bed to smoke. She said she did not know that Resident #49 wanted to smoke cigarettes and was being denied by staff. She said the resident rights are supposed to be reviewed in resident council meetings but a copy of it was in the admission packet. She said not all residents sign their admission packets and may not have received a copy of the resident rights. She said residents not knowing their residents' rights could make them feel unheard with no voice in their home leading to depression and anxiety. During an interview on 8/04/22 at 07:00 PM, the DON, she said she would expect residents to be treated with respect and dignity and to be covered as much as possible when receiving care. During an interview on 8/04/22 at 7:34 PM, the Administrator said residents should be provided privacy by closing the door, pulling a curtain, and keep them covered as much as possible when providing care. She said it could hurt the resident's feelings and it was a dignity issue. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Resident Rights policy dated February 2021 revealed .employees shall treat all residents with kindness, respect, and dignity .basic rights to all residents of the facility include the right to: a dignified existence, be treated with respect, kindness, and dignity, exercise his or her rights as a resident of the facility and as a resident of the United States, self-determination, privacy and confidentiality, voice grievances to the facility or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal, communicate in person and by mail, email, and telephone with privacy, communication with and access to people and services, both inside and outside the facility .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 44933 Based on observation, interview, and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of needs and preferences for 3 (Resident #23, Resident #32, Resident #49) of 21 residents reviewed for reasonable accommodation of needs/preferences. The facility failed ensure Resident #23, Resident #32, and Resident #49's call light was accessible. This failure could place residents at risk for unmet needs and decreased quality of life. Findings included: 1. Record review of a face sheet revealed Resident #23 was a [AGE] year-old male, that admitted to the facility on [DATE] with the diagnoses of anemia (low iron in the blood), hypothyroidism (A condition in which the thyroid gland doesn't produce enough thyroid hormone), and edema (swelling). Record review of an MDS dated 6 /08/2022 indicated Resident #23 had a BIMS of 08, which indicated a mild cognitive deficit. Resident #23 required extensive to dependent assistance with ADL. Resident #32 was understood and understood others. Record review of Resident #23's care plan dated 7/27/2022 addressed Fall Risk, urinary incontinence, and ADL function, which all had an intervention of call light to be in reach at all times. During an observation on 08/01/2022 at 9:33AM Resident #23's call light was wrapped around an electrical outlet in the center of the room, out of reach. During an observation on 8/1/2022 at 2:19 pm, Resident #23's call light continued to be wrapped around the electric outlet in the middle of the room between the 2 beds. Resident #23 stated he would like his call light clipped to his shirt everyday just in case he needed it. Resident #23 stated he pushed his light when his roommate was getting out of bed without assistance to let them know. Resident #23 indicated he either screamed for help or waited until someone came in when he could not reach his call light. During an observation on 8/1/2022 at 5:10 pm, Resident #23's call light wrapped around the electric outlet in the middle of the room between to the 2 beds in the room. Resident #23 was in bed and unable to call for help. During an observation on 8/2/2022 at 7:33AM, Resident #23 was in bed. The call light continued to be wrapped around the electric outlet in the middle of the room between the 2 beds. During an observation on 8/2/2022 at 10:15PM, Resident # 23 was in bed. The call light continued to be wrapped around the electric outlet in the middle of the room between the 2 beds in the room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/3/2022 at 9:12AM, Resident #23 was in bed and call light continued to be wrapped around the electric outlet in the middle of the room between the 2 beds. 2. Record review of a face sheet revealed Resident #32 was a [AGE] year-old-male that was admitted to the facility on [DATE] with the diagnosis of CVA (stroke), hemiplegia of dominant side (paralysis on right side of body), and protein calorie malnutrition. Record review of the MDS dated [DATE] revealed Resident #32 was usually understood and usually understood others. Resident #32 was noted to have a BIMS of 04 which indicated a significant cognitive impairment and he required extensive assistance with ADLs such as transfer, bathing, and bed mobility. Record review of Resident #32's fall care plan dated 6/29/2022 revealed an intervention of always keeping the call light in reach. During an observation on 08/01/2022 at 9:33AM, Resident #32 had no call light in reach. Resident #32's call light was on the floor beside the bed. During an observation on 8/1/2022 at 5:10 pm, Resident #32's call light was wrapped around the electric outlet in the middle of the room between to the 2 beds in the room. Resident #32 was in bed and unable to call for help. During an observation on 8/2/2022 at 7:33AM Resident #32 was in bed. The call light continued to be wrapped around the electric outlet in the middle of the room between the 2 beds. During an observation on 8/2/2022 at 10:15PM, Resident # 32 was in bed. The call light continued to be wrapped around the electric outlet in the middle of the room between the 2 beds in the room. During an interview on 8/3/2022 at 9:44 AM, CNA L stated Resident #23 did use his call light for help for himself and his roommate. CNA L stated she was not aware if Resident #32 could use his call light. CNA L stated all residents should have a call light within reach of them anytime they are in their room unattended by staff. 3. Record review of the face sheet dated 8/4/22 revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis, need assistance with personal care, and muscle wasting and atrophy (shortening). Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance to total dependence for ADLs. Record review of the undated care plan revealed Resident #49 was a fall, safety, elopement risk with interventions of encourage use of call light and keep call light within reach. During an observation and interview on 8/1/22 at 10:30 a.m., Resident #49 was in bed with his call light on the floor. Resident #49 said he did not know where his call light was but even if he had it, staff do not answer it. He said if he needed assistance then he must holler out but he said his voice was not that loud so he could not be heard. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/2/22 at 12:16 p.m., Resident #49 was asleep in his bed. Resident #49's call light was hanging down the side of his bed, not in reach. During an interview on 8/3/22 at 10:37 a.m., CNA N said she was the CNA staff coordinator and worked the floor. She said call lights should be always in reach and functioning. She said call lights not being in reach or non-functioning could cause falls and resident's needs not being met. During an interview on 8/4/22 at 5:40 p.m., the DON said call lights not being answered, in reach, or non-functioning could cause more falls. She said anyone that enters the room to provide care for the residents, was responsible for the call light being in reach. During an interview on 8/4/22 at 6:30 p.m., the Administrator said residents having their call light in reach and functioning was very important for everyone. She said having non-functioning call light or call light not within reach could lead to falls, increased skin problems, and unhappy residents. She said all CNAs and nurses were responsible for ensuring call lights in reach and functioning properly. She said if staff found a call light out of reach, they need to put it within reach. Record review of a signed in-service dated 3/2/2022 given by RN M stated, calls lights must always be in reach and in working order for all residents. Record review of the facility's Answering the Call Light policy dated March 2021 revealed .the purpose of this procedure is to ensure timely responses to the resident's requests and needs .when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident . Record review of the facility's Accommodation of Needs policy dated March 2021 revealed .our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being .

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 44933 Based on interview and record review, the facility failed to ensure that 7 of 7 residents (AR2, AR3, AR4, AR5, AR7, AR9, and AR10) had a right to organize and participate in resident groups, in that: The facility did not have monthly resident council meetings . This failure could place residents at risk of not having the right to voice their concerns in a Resident meeting setting. Findings include: During a confidential resident group meeting on 8/2/22 at 10:02 a.m., AR 2, AR3, AR4, AR5, AR7, AR9 and AR10 said resident council was not held on a regular basis. AR4, AR7, and AR9 said it had been greater than 6 months since the last resident council meeting. AR2, AR3, AR5, and AR10 said they had not been invited or informed of resident council meetings. AR4, AR7, and AR 9 said when they did have resident council meetings, it was held in the open dining room. During an interview on 8/3/22 at 10:37 a.m., CNA N said she used to be the activity director until March 2022. She said the facility did not have one until July and she was training her. She said the last meeting she recalled having was in March 2022. She said she did not have all her previous meeting minutes because the old DON stole them because they had incriminating evidence related to poor resident care. During an interview on 8/4/22 at 5:40 p.m., the DON said residents had the right to have resident council meetings and to meet in a private area. She said not having privacy could make them feel like they could not speak freely due to retaliation. She said residents had not complained to her about not having meetings. During an interview on 8/4/22 at 6:30 p.m., the Administrator said the facility did not have resident council meetings on a regular basis. She said the facility had not held a meeting in last 4 or 5 months. She said they needed the activity director, who was now the CNA supervisor, to work on the floor daily. She said it was the residents right to having regular meetings. She said not having meetings could make the residents feel unheard and have no voice in their home. She said this could lead to depression and anxiety because everyone deserved to have a voice. Record review of the facility's Resident council policy dated February 2021 revealed .the facility supports residents' rights to organized and participant in the resident council .the purpose of the resident council is to provide a forum .have input in the operation of the facility .discussion on concerns and suggestions for improvement .consensus building and communication between residents and facility staff .disseminating information and gathering feedback .the facility encourages residents who are willing to participate .resident council group is provided space, privacy and support to conduct meetings .council meetings are scheduled monthly or more frequently if requested by residents .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 44933 Based on observations, interviews, and record reviews the facility failed to ensure residents had a safe homelike environment for 1 of 1 facility reviewed for environment. The facility failed to remove food debris off the floor and clear and red splash residue off the wall, headboard, and nightstand of Resident #10. The facility failed to ensure the residents were provided with a safe, sanitary, comfortable homelike environment for Resident #10, Resident #20, and room [ROOM NUMBER]. The facility failed to provide residents with clean and non-malodorous common areas. These failures placed residents at risk of living in an unsafe, unsanitary, and uncomfortable environment. Findings included: During an observation on initial tour on 08/01/2022 at 9:00 AM, the facility was dirty. The smell of ammonia when walking in the front door was so strong it made the surveyors eyes water. There was trash and food on the floor in the living area upon entrance. There were water bugs on the floor that were 2-3 inches in length. There was old food and feces on the wall in the room the surveyors were placed in to work. The shower room had used gloves on the floor, dead water bugs (3), the trash was overflowing, and the sharp containers were full. Dirty clothes and towels were on the floor in piles. The Administrator kicked a dead water bug approximately 2 inches in length to the side as she escorted survey team to the room, they were to work in. During an observation and interview on 8/1/22 at 10:30 AM, On Resident #10's floor was pieces of a grilled sandwich and French fries. On Resident #10's wall, headboard, and nightstand were clear and red shiny splashes. Hanging from Resident #10's ceiling was fly trap covered in flies and gnat trap full of gnats. Resident #10 said the food on the floor was probably from yesterday's lunch or dinner. Resident #10 was lying flat in his bed with food crumbs on his beard, chest, and bed. He said he likes to drink and eat flat, so food and drinks go everywhere. He said because he cannot see well, he knocks things over a lot. He said the fly and gnat trap were nasty but needed because of the dang bugs. He stated, housekeeping come whenever the hell they want. During an interview with the Administrator on 8/01/22 at 2:15 PM, requested for the maintenance logbook and the floor maintenance request logbook was made, however the Administrator was not able to locate them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 8/1/2022 at 2:17 PM, room [ROOM NUMBER] had food wrappers on floor, browns stains on wall beside the beds, reddish brown stains on the wall next to the head of the bed, and missing paint (6-to-12-inch chunks) throughout the room in 3 different spots. During an observation on 8/1/22 at 3:30 PM, the secure unit had a strong odor of urine and feces. During an observation on 8/2/22 at 6:55 AM, two surveyors entered the facility. On the way down the hall to the surveyor's conference room the odorous hall made one surveyor gag. During resident council meeting on 8/2/2022 at 10:02 AM, 10 anonymous residents stated they had roach, ants, flies, and gnat problems at the facility. Five of the anonymous residents agreed having a bug problem caused them to have decreased appetite. During an interview and observation on 08/02/22 at 10:50 AM, in Resident #20's room there was a large area of missing paint with red staining in one area on one wall, there was large scrapes on the wall by the door, there was a hole in the closest door, the windowsill was broken off with exposed rough wood, and an approximate two-inch sunken area in the tile of the bathroom. Resident #20's family member said the facility needed an overall update. She said there was a large area of missing paint on her mother's walls and scrapes that the previous roommate had done. Resident #20's family member said, Resident #20 would not want her room to look like this and I would not want it in my home. During observation on 8/2/2022 at 6:30 PM, a state surveyor noted to have a roach crawling on her bag as the facility was exited. During a phone interview on 8/04/22 at 1:16 PM with the pest control company technician, he said he came once a month and sprayed outside for ants and bugs and baited the outside rodent stations. He said he only sprayed the common areas inside the building, such as the dining room and the conference room because the spray required residents to be out of the area for at least an hour. He said he would only spray residents' rooms when a problem was identified and reported to him. He said no one had told him that there was a roach, ant, gnat issue recently, but he was scheduled to return on 8/10/22 and would inspect for roaches and spray as needed. He said he was last at the facility on 7/26/22. During a phone interview on 08/03/22 at 2:57 PM with the local Police Department Investigating officer that responded to a non-related incident at the facility on 6/28/22, she said there was an air mattress on the floor and the facility smelled bad. She said she felt bad for the residents. Record review of a [local]Police Department report dated 6/28/22, while at the facility investigating a non-related incident revealed . the reporting officer said the facility was not good, she saw an air mattress on the floor for a resident's bed and the air mattress was dirty .she said it smells when you walk in . During an interview on 8/04/22 at 5:40 PM with the DON, she said they needed a more reliable maintenance man because the current one has been out on and off or he only comes in 2-3 days a week. (continued on next page)

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Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview 8/04/22 at 7:34 PM with the administrator, she said she would expect the residents to have a clean homelike environment. She said the Maintenance Supervisor had been out sick for a while and was only able to work 1-2 times a week. She said the Housekeeping Supervisor would try to fix immediate issues when he was notified. During a phone interview on 8/04/22 at 7:45 PM with the Maintenance Supervisor, he said he had been out sick for a while and was only able to work occasionally. He said people usually reported issues to him verbally and he did not keep a log. He said there was certain assigned tasks to him on their electronic system. Record review of a facility in service titled Shower Rooms dated 1/20/22 revealed .shower rooms would be kept clean and tidy at all times . shower room and surfaces would be disinfected between resident uses . Record review of the facility's policy titled Homelike Environment dated February 2021 revealed . residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible . facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, including: clean, sanitary, orderly environment, inviting colors and decor, pleasant, neutral scents . facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting, including institutional odors . Record review of the facility's policy titled Maintenance Service dated November 2021 revealed . maintenance service shall be provided to all areas of the building, grounds, and equipment . functions of maintenance personnel include .maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines, maintaining the building in good repair and free from hazards, maintaining the paging system in good working order, providing routinely scheduled maintenance service to all areas . a copy of the maintenance schedule shall be provided to each department director so that appropriate scheduling can be made without interruption of services to residents . 46062

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44933 Based on interview, and record review, the facility failed to ensure that 10 of 10 residents (Anonymous Resident 1-Anonymous Resident 10) had a right to organize and participate in resident groups, in that: AR1-AR10 in a confidential resident group interview felt they could not complain about care without worrying that someone would retaliate. This deficient practice could place the residents at risk for decreased quality of life and feelings of hopelessness. Findings included: During a confidential resident group meeting on 8/2/22 at 10:02 a.m., AR1-AR10 were in attendance and all 10 residents wished to remain anonymous. All 10 anonymous residents felt like they could not be open about their concerns in the open for fear of retaliation. All 10 anonymous residents agreed they feared retaliation if they complained about CNAs and nursing staff. Several residents said the staff would retaliate by not answering call lights, confronting them about complaining, or take even longer to answer their call light. During an interview on 8/4/22 at 5:40 p.m., the DON said residents should know how to file grievances and should not feel like staff will retaliate against them. She said residents could feel depressed and scared if they cannot file grievance without fear of retaliation. During an interview on 8/4/22 at 6:30 p.m., the Administrator said residents feeling like they cannot complain or file a grievance without retaliation was not acceptable. She said no resident deserved to feel they cannot make complaints known. She said if residents felt they cannot complain, then their quality of life will suffer. She said the facility did grievances at the facility and they are followed through with resolutions. She said she was unaware the residents felt this way. Record review of the facility's Resident Rights policy dated February 2021 revealed .exercise his or her rights without interference, coercion, discrimination or reprisal from facility .voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal .

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46299 Based on observation, interview and record review, the facility failed to ensure the right of the residents to be free from abuse for 3 of 21 residents reviewed for abuse and neglect. (Resident #29, Resident #49, and Resident #1) - Resident #29 was hit multiple times in the face and bit on the thigh by TCNA O during a physical altercation. -After suspension of 3 days,TCNA O returned to work at the facility which later resulted in TCNA O verbally abusing Resident #49 on [DATE]. TCNA O continued to work until she quit on [DATE]. -The facility did not provide appropriate intervention to protect all residents, after a resident-to-resident altercation in which Resident #1 repeatedly kicked another vulnerable resident in the head. -The facility failed to follow the care plan of assessing Resident #1 for a specially designed therapeutic unit upon readmission to the facility. These failures could place residents at risk abuse, neglect, and serious bodily harm. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 1:15 p.m. While the IJ was lifted on [DATE] at 8:00 p.m. the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of patterned due to the facility's need to evaluate the effectiveness of their corrective systems. Findings included: 1. Record review of a face sheet dated [DATE] indicated Resident #29 is a [AGE] year-old female and was admitted to the facility on [DATE]. The resident had diagnoses of mental/mood/behavioral disorders, Major Depressive Disorder and Dementia (the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities). Record review of the [DATE] Quarterly MDS assessment indicated Resident #29 was understood and had a BIMs of 06, indicating severely impaired cognition at times. She did reject care for 4 to 6 days of the 7-day review period. She required supervision set-up only for walking. Record review of Resident #29's Comprehensive Care Plan dated [DATE] revealed staff must maintain a calm environment and approach when caring for Resident #29. Record review of complaint intake #360678 and facility investigation dated [DATE] indicated the incident was reported on [DATE], revealed TCNA O bit Resident #29 on the thigh during an altercation, which also resulted in a scrape on Resident #29s left elbow. TCNA O was suspended during the investigation, a police report was completed, a staff in-service on abuse was completed and the completed investigation was faxed to the state on [DATE] with the allegations noted as unconfirmed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the [local] Police Department Case report dated [DATE] at 08:31 AM revealed an assault against elderly or disabled individual (Resident #29). TCNA O physically assaulted Resident #29 after she wanted to call daughter around 10:00 PM and staff would not allow it. TCNA O came into the resident's room, sat on her bed and hit her. TCNA O entered Resident #29s room again, jumped on her bed and hit her with her fists, causing the resident to become unconscious at times; also told Resident #29 she was in a mental institution. Then when the resident said she would report TCNA O to the administration, both (Resident #29 and TCNA O) fell off the resident's bed and hit the tile floor, the resident wrapped her thighs around TCNA O's neck and then the TCNA O bit the resident on the thigh. TCNA O then hit the resident again in the face with closed fists and left the room. Resident #29 had an injury to her left elbow with a band aid covering it with blood on it, her shirt and sheets, but her right thigh did not have teeth marks. TCNA O was read her [NAME] Rights. Due to the fact that TCNA O was an employee with the nursing home and was working in the Mental health side of the facility she has the duty to protect and care for the residents who she oversees. TCNA O did not show restraint verbally or physically to Resident #29 due to being upset with the threat of being reported to administration. Resident #29 was a [AGE] year-old fragile elderly woman who could not protect herself against a healthy young [AGE] year-old TCNA O. The nursing home did not call for police when this assault occurred, they called 9 hours after the assault to report this to the police. Record review of the CPS/APS Intake Report dated [DATE] revealed Resident #29 resided at facility and had been physically assaulted three times by TCNA O working overnight, between 11:00 PM and 01:00 AM. TCNA O had bit the resident on her inner right thigh with her teeth and punched her multiple times with a closed fist causing the resident to lose consciousness. A wound to Resident #29s left elbow was band aided over and still had bleeding noted. TCNA O was suspended, and a report was filed for assault against elderly or disabled individual. During an interview on [DATE] at 04:48 PM with Resident #29, stated she went down the hallway, and asked TCNA O to talk/call to her family member, and the staff would not let her. I tried to open doors and pulled the fire alarm to get the employees attention. TCNA O asked me to go to my room. So, I did. But I still wanted to call my daughter. TCNA O came into my room, jumped on my bed, saying this was a mental institution. I told her (TCNA O) no, this was a place for the elderly. She came back in my room more than once; I said some things and she said, don't talk to me. I threw a bottle hard at TCNA O that missed her because she kept getting near my face, so I pulled her hair and we both fell to the floor, and then TCNA O did bite me on my thigh. I was in fear for my safety with her working here, none of that had to happen if they would have let me call my family member none of that would have happened. She kept coming back in my room, antagonizing me and then left the building. I had an injury to my left elbow that bled and a bite mark on one of my thighs. I filed a police report and staff talked to me about the incident. I thought TCNA O was fired because she should not treat residents that way. Nothing like that had ever happened before that incident at the facility. In an attempted telephone interview with TCNA O on [DATE] at 04:58 PM revealed message call cannot be completed due to the called party is unavailable. During an interview on [DATE] at 09:00 a.m., with the Administrator and DON, they were asked if they could get ahold of TCNA O. During an interview on [DATE] at 05:37p.m., the Regional Nurse reported she made attempts to reach TCNA O all day and were unsuccessful. The facility eventually had contact with TCNA O on [DATE] and she gave her notice of termination. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 04:49 PM, CNA CC revealed he stated he was there during the incident with Resident #29 and TCNA O. It was a verbal confrontation between Resident #29 and TCNA O, it then became physical from what I heard, and then when TCNA O went back into the room with Resident #29, I went back to the unit for security reasons. Resident #29 said that TCNA O had bit her, and there was a bite mark on Resident #29's leg. I had abuse training prior to this incident, in-services, and have been a CNA for [AGE] years, I have learned some things. He did not feel TCNA O was abusive towards the resident, even after hearing what took place. Interviews on [DATE] at 12:24 PM with LVN F, revealed she stated I worked the night shift on whatever night that happened, and at approximately 10:00 PM or later, I got back from my break and RN DD and CNA CC were back in the secured unit. TCNA O was the aide on the secure unit and had left the facility after an incident with Resident #29 without telling staff what happened. Resident #29 said she and TCNA O had exchanged words, ended up on the ground, Resident #29s legs around the aide's neck, and the aide bit her. LVN did note a circular red mark on Resident #29s right thigh near her pelvis, but she did not chart a skin assessment. TCNA O was not at work for a while after that incident. She called the DON after that to report what happened. LVN F stated I had abuse training prior to the incident and definitely after the incident. Resident #29 had never been aggressive to any staff physically; this was not like her, so I settled her down and made sure she felt safe, because TCNA O was gone from the building, and she had no other issues that night. LVN F stated allowing the residents to call her family member maybe would have helped prevent this whole incident, she may have asked TCNA O to call her family member, I do not know. During an interview on [DATE] at 02:57 PM with the Police Officer revealed that night ([DATE]) around 11:30 PM on the secured unit at the facility, TCNA O said Resident #29 could not call her family member at night. This upset the resident and so she pushed on alarmed doors to irritate the staff. The resident was just upset, saying she wanted to report TCNA O, and TCNA O was mad that Resident #29 was going to report her. The resident had gone to her room, and TCNA O came into her room, sat on her bed. The resident wrapped her legs around TCNA O's neck, they both fell to ground and TCNA O bit her leg. Resident #29 was protecting herself she said, that was why she protected herself. The resident's elbow was busted open, black, blue and purple and there was dried blood on her bedding and clothing. I took pictures of the teeth marks on her leg/thigh, and TCNA O admitted she had punched Resident #29 in the face and bit her. The facility should have called the police right away when it happened so we could have taken Resident #29 to the hospital to get checked out. TCNA O should have never been seated on the resident's bed, antagonizing her. Resident #29 was with it, she remembered everything. During an interview on [DATE] at 5:00PM, the Administrator stated she was aware of the incident from the DON that morning after the incident between TCNA O and Resident #29 and reported it. It happened because the staff would not allow the resident to call her family member. This upset the resident and she acted out, pulling the fire alarm for attention. It was reported by TCNA O that Resident #29 attacked her, kicked her causing them to fall to the floor. The resident wrapped her legs around the NAs neck and TCNA O bit the thigh of the resident for her to release. The Administrator stated the facility had trained their employees on de-escalation of combative residents and TCNA O should have left the resident alone and allowed her to call her family member to calm the resident down. TCNA O just worked the front hall instead of the secured unit after the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 5:00PM, the Corporate RN stated police had come out and read TCNA O her [NAME] rights, so the facility thought that meant she had to be terminated. TCNAs references and background check were fine, that is why she was hired. Not firing her could affect every resident in the facility she had contact with after this incident by allowing further abuse. During an interview on [DATE] at 01:04 PM, the DON stated I got a call from LVN F about the incident that morning and reported it to the Administrator right away. Record review of the facility staffing schedules [DATE] to [DATE] revealed TCNA O worked at least 20 shifts at the facility since the abuse to Resident #29 and Resident #49. 2. Record review of the face sheet dated [DATE] revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis (a disease that impacts the brain, spinal cord, and optic nerves), need assistance with personal care, schizoaffective disorder, bipolar type (a chronic mental health condition that involves symptoms of both schizophrenia and a mood disorder), anxiety disorder, and depression. Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance to total dependence for ADLs. Record review of an undated care plan revealed Resident #49 exhibited verbally abusive behavioral symptoms. Interventions included ignore resident's verbal abuse when directed at you and refocus conversation when resident becomes verbally abusive. During an interview on [DATE] at 11:49 a.m., Resident #49 stated he and a staff member exchanged words one day. He said it made me mad and sad because she talked about his mother, and she was his best friend. During an interview on [DATE] at 4:23 p.m., Resident #30 said last month, TCNA O cursed out a resident because Resident # 49 threw a tray at her. Resident #30 said I could hear her all the way down to my room and she talked about his momma and dad. She stated TCNA O said, Your mom is bitch and Your dad is a __ and my auntie works here. She said TCNA O was CNA N's niece. During an interview on [DATE] at 2:30 p.m., Resident #30 said a verbal altercation between a resident and a CNA happened. She said the altercation was so loud, staff from the front of the building came to the back to see what was happening. She said she was not sure what occurred, but TCNA O cursed a resident down the hall and talking about his mom was a whore and stated, she was going to lose her job today. She said TCNA O cursed the resident out. During an anonymous interview on [DATE] at 11:00 a.m., AR said ,d+[DATE] weeks ago, he/she heard an aide cursed out a resident. AR said the resident threw his tray and the aide screamed, your mom is a bitch. AR said it happened on [DATE]. AR said he/she did not know who the resident or aide were. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:03 a.m., TCNA L said on [DATE], TCNA O did curse out Resident #49. She said the facility was short staffed that weekend and TCNA O came to the back hall to help. She said TCNA O went into Resident #49's room to drop off his lunch tray and screaming started. She said Resident #49 did not throw a plate at TCNA O, put tossed the plate cover on the floor and it did not touch her. TCNA L said her and LVN A pulled TCNA O out of the room and told her to go outside. TCNA L said she told CNA N, the CNA supervisor, about the verbal altercation. She said she had received abuse training upon hire. During an interview on [DATE] at 8:45 a.m., LVN A said a loud altercation happened between TCNA O and Resident #49 on [DATE]. She said Resident #49 threw the lid to the plate and it almost hit TCNA O. TCNA O then cursed Resident #49 and screamed at her aunt who worked here and stated she would lose her job today. LVN A said she attempted to deescalate the situation by separating TCNA O from Resident #49 and told her to go outside for a while then back to the front hall. LVN A said the CNA N showed up at the facility and took TCNA O outside. LVN A said she did not see TCNA O for the rest of the day. She was not sure if TCNA O went home or just stayed down on the front hall. LVN A said she did not assess Resident #49 after the altercation, physically or mentally. LVN A said she felt the altercation was verbal abuse. LVN A said because the on-call nurse and CNA N, who was the CNA supervisor, were in the building they would report the abuse to the administrator. During an interview on [DATE] at 5:43 p.m., LVN C said Resident #57 told him about a ruckus that happened over the weekend. He said Resident #57 attempted to play a recording, but it was not working properly. LVN C said he could hear people screaming at each other, but he only heard it for a few seconds. He said Resident #57 said he did not know who was in the recording, but they created a big ruckus. LVN C said he called the administrator on [DATE] and told her about the recording because he felt obligated to notify her in case it was verbal abuse. During an interview on [DATE] at 10:37 a.m., CNA N said TCNA O and Resident #49 did have an altercation on [DATE]. She said TCNA O called her and told her about it. She said TCNA O told her Resident #49 threw a plate at her and called her out of her name. She said she told her to leave, and she could not talk to residents like that even if they call you the N word. She said on [DATE], LVN C told the Administrator about a recording Resident #57 had on his phone, but he could not hear enough to decipher who it was. LVN C told the administrator Resident #57's phone was not acting right but he felt like she should look into it. CNA N said the Administrator called her to investigate the recording Resident #57 had. She said she asked Resident #57 to listen to the recording he told LVN C about, but he said he did not have it. She said since I could not hear the recording, then there was nothing to investigate. She said the altercation between TCNA O and Resident #49 was abuse. She said TCNA O did not have sufficient abuse and deescalating training before hire. She said the facility was so short staffed when she started, we just need her to work and did not have time to give her sufficient training. She said she did not fire TCNA O because she asked other residents about her care, and no one complained and some even requested her to work on their hall. She said she asked staff about her behaviors, and no one complained. During an interview on [DATE] at 12:45 p.m., the Administrator was notified by this surveyor and the team lead of the survey, of reports from staff and residents, verbal abuse had occurred between a resident and staff. The Administrator was also notified of reports from staff, she was notified of the verbal altercation prior to the survey. The Administrator denied any knowledge of abuse in the facility. The Administrator indicated TCNA O was suspended from [DATE] to [DATE]. TCNA O returned to work and quit on [DATE], but her last day worked was [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 5:40 p.m., the DON said TCNA O's last day worked was [DATE]. She said she was not told about the incident with Resident #49 and TCNA O. She said she was out of town, and no one called her. She said after the first incident with, she did in-service on the prosperity unit, and asked staff about her behavior towards other residents. She said no one complained about her. She said TCNA O was suspended for ,d+[DATE] days but disciplinary action was not done. She said she only probably signed the suspension paperwork. She said it should be in her personnel file. During an interview on [DATE] at 6:30 p.m., the Administrator said abuse was not tolerated and everyone had been educated on the chain of reporting. She stated she was unaware of the verbal abuse that occurred between TCNA O and Resident #49. She said verbal abuse could make a resident feel threatened and scared. She said it could make residents not trust the staff and have decreased quality of life. 3. Record review of the face sheet revealed Resident #62 was a [AGE] year old male with diagnoses including CVA (stroke), hemiplegia to dominant side (paralysis of one side of the body) and a PEG tube (feeding tube). Record review of a progress noted dated [DATE] indicated Resident #62 was up ambulating at 7:25pm, was found on the floor non responsive at 9:00PM, CPR was initiated, and at 9:15pm Resident #62 was transported by EMS to the local hospital where he was pronounced dead. Record review of the face sheet revealed Resident #1 was [AGE] year-old male that admitted on [DATE] with diagnoses including CVA (stroke), bipolar disorder (disorder associated with episodes of mood swings) and hemiplegia (one-sided paralysis). Record review of the quarterly MDS dated [DATE] indicated Resident #1 had a BIMS of 15, which indicated no cognitive impairment. The MDS indicated he required limited assistance with ADLs, and he had physical behavioral symptoms directed towards others and verbal behavioral symptoms directed toward others exhibited 1 to 3 days. Record review of a care plan for Resident #1 dated [DATE] stated: -Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by aggressive behavior. Resident was noted kicking another resident in the head. -The goal stated: Resident will not harm self or others secondary to socially inappropriate/disruptive behavior. Current behavior pattern: physically aggressive behavior (kicking another resident). -The approaches stated: Assess resident for placement in a special designated therapeutic unit. Assess whether the behavior endangers the resident, and/or other residents. Intervene if necessary. Remove resident and/or other resident's unsafe situations. When resident begins to become socially inappropriate/ disruptive, remove from situation, assess needs, and provide care if needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a nurses note dated [DATE] at 7:55AM, written by LVN C indicated I could hear the resident yelling from his room as I was assisting CNA to pass breakfast trays, I stopped, ran to the resident's room, and noted him kicking another resident who was on the floor in the head, I immediately stopped the altercation and assessed both residents (Resident #1 and Resident #62). I removed fell ow resident (Resident #62) from the floor once I assessed him only noted he had a reopened skin tear above right brow from a previous fall. Resident #1 stated that Resident #62 came in his room and grabbed his shirt and would not let go so he pushed him off him and when he fell , he began to kick him (Resident #62) in the head. DON notified who is to notify the administrator. Record review of a nurses note dated [DATE] at 8:15 AM written by LVN C, indicated NP Q was notified of the altercation, but no new orders and ISNP R called no answer. Record review of a nurses note dated [DATE] at 8:19AM, written by LVN C, indicated ISNP R was made aware of the altercation with no new orders. Record review of nurses note dated [DATE] at 2:44PM, written by LVN R indicated Resident (Resident #1) requested to talk to his family member, Called family member. Resident #1 got upset after talked. Shouting move, bitches. Redirected resident and took him to his room. Record review of nurses note dated [DATE] at 10:45 AM, written by the SW indicated, Resident # 1 had been referred to [local] Behavioral hospital . Record review of progress notes dated [DATE] at 6:09 PM written by LVN P revealed Resident #1 returned to facility on [DATE] from [local] Behavioral Hospital. Record review of progress notes revealed Resident #1 was seen by psychologist on [DATE], one month after readmission from the behavioral hospital. Record review of EHR on [DATE] revealed, no assessment for placement in a special designated therapeutic unit upon readmission to the facility. During an observation on [DATE] at 8:45am, Resident #1 was observed yelling at another resident, I will kill you! Get out of my room. Resident #26 was noted wandering in and out of several rooms on the central hallway that morning. Resident #26 was removed from Resident #1's room and redirected by TCNA L. During an interview on [DATE] at 10:08AM, the SW revealed Resident #1 had been to the behavioral hospital several times since his admission for being verbally and physically aggressive. The SW also revealed, Resident #1 did not want to discharge to the behavioral hospital again after the incident on [DATE], so the facility made a deal with him. If he would go to the behavioral hospital, take his medications, and had no behaviors while he was gone then the facility would try him outside of the secure unit. The SW indicated Resident #1 had no further physically aggressive behavior and he did not feel his roommate was in any danger of physical or verbal abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:37 AM, CNA N revealed that Resident #1 had a temper problem. CNA N revealed Resident #1 had to be redirected several times a week for yelling and cursing at residents and staff members. Resident #1 did not like other people in his room and would become irate and throw things if residents wandered into his room. CNA stated there were several little ladies that wandered on the central hall where Resident #1 lived. CNA N stated the staff tried to keep an extra eye on him and answer his call light as quickly as possible because he had zero patience. CNA N revealed Resident #1 was still having these behaviors since his readmission from the behavioral hospital. During an interview on [DATE] at 5:40pm the DON stated she was unaware of Resident #1 being verbally aggressive with wandering residents. The DON stated, Resident #1 had no reported behavior problems since he returned from [local] Behavioral Hospital. During an interview on [DATE] at 6:40pm the Administrator stated she was unaware of any verbal aggression with wandering residents. Resident #1 had no reported behavioral problems since he returned from the behavioral hospital. Resident #1 was seen by the psychologist and no aggression was noted during that assessment. A facility policy titled Resident to Resident Altercations dated February 2021 stated the facility will make any necessary changes in the care plan approaches to any or all of the involved individuals; review the events with the nursing supervisor and possible measures to try to prevent additional incidents; document in the resident's clinical record all interventions and their effectiveness. Record review of the facility Abuse Prevention Program Policy dated February 2021 revealed our residents have the right to be free from abuse, including verbal, mental or physical abuse. Our center will protect residents from harm during investigations of all abuse investigations. All reports of resident abuse shall be promptly reported to local, state and federal agencies and thoroughly investigated by management. The administrator was notified on [DATE] at 3:19 p.m., an Immediate Jeopardy situation was identified due to the above failures and the IJ template was emailed to the administrator on [DATE] at 3:37 p.m. The facility's plan of removal was accepted on [DATE] at 6:55p.m. and included: Plan of Removal Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on [DATE], for abuse. Action Item: The Temporary C.N.A. is suspended pending investigation - Person Responsible: Nursing and administration - Timeline for completion: [DATE] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Action Item: Verbal abuse allegation reported to the administrator by the surveyor on [DATE] was reported to the state on [DATE]. Resident safe surveys were completed on [DATE] no other resident concerns were noted. Staff interviews will be completed by [DATE]. Investigation on verbal abuse will be completed by [DATE]. - Person Responsible: Nursing and administration - Timeline for completion: [DATE] Action Item: The aggressor was assessed at [behavioral center]and deemed not to be a risk to others on [DATE] and was sent back to the center on [DATE]. The psychologist assessed the resident on [DATE] and deemed the resident not to be a risk to others. The Regional Nurse Manager reviewed the residents care plan and interventions in place to care for the resident on [DATE], one intervention was resolved as related to the approaches: assess for placement in a therapeutic unit. The resident was treated at [behavioral center] and did not need the therapeutic unit post care. Duplicate interventions were resolved on [DATE] by the Regional Nurse Manager. A staff member will be present outside of the resident's room to protect other residents until resident is deemed not a threat to others. Referral to psychiatric/behavioral service provider on [DATE]. Care plan updated to reflect monitoring on [DATE] by the Regional Nurse Manager. - Person Responsible: Nursing and administration - Timeline for completion: [DATE] Action Item: Staff education completed on abuse prevention, abuse reporting, abuse investigation, de-escalation, managing unwanted behaviors, and interventions to protect other residents from altercations. Staff will receive education prior to working their next shift. The center performance improvement plan was initiated on [DATE] and updated on [DATE] by the Regional Nurse Manager. - Person Responsible: Nursing and administration - Timeline for completion: [DATE] MONITORING: On [DATE], the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by: - Interview on [DATE] at 10:10am, the administrator stated she suspended temporary CNA O pending investigation of abuse. - Observation on [DATE] at 8:20 am, Resident #1 had an employee stationed in front of door. - Interview on [DATE] at 2:15pm, the administrator stated a tele visit was held between Resident #1 and psychologist. - Record review of psychologist note dated [DATE] revealed Resident #1was calm, sociable, upbeat. Resident #1 interacted well, and mood appeared stable. No behavioral symptoms noted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Interviews on [DATE] at (8:20 p.m., LVNC); (8:25 p.m., Med Aide D); (6:08 p.m. CNA E), (6:30pm LVN F); (6:35 p.m. G), (6:21 p.m. CNAN), (6:38 p.m. LVN I), (6:50p.m. SSD), (6:51p.m. BOM) and (6:52pm TCNA L) revealed they had received education on abuse prevention, abuse reporting, abuse investigation, de-escalation, managing unwanted behaviors, and interventions to protect other residents from altercations. - Inservice records dated [DATE] revealed they had received education on abuse prevention, abuse reporting, abuse investigation, de-escalation, managing unwanted behaviors, and interventions to protect other residents from altercations. - Safe surveys for all cognitive residents revealed no reported abuse. Family surveys for all cognitively impaired residents revealed no suspicions of abuse. On [DATE] at 8:00 p.m., the administrator was informed the IJ was removed; however, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of patterned due to the facility's need to continue to monitor the effectiveness of their plan of correction. 44933

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F 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interviews and record reviews, the facility failed to ensure residents were free from involuntary seclusion for 1 (Resident #50) of 21 residents reviewed for involuntary seclusion. The facility failed to ensure Resident #50 was free from involuntary seclusion. This failure could place residents at risk of feeling isolated, fearful, hopelessness uncomfortable, disrespected, decreased self-esteem, and diminished quality of life. Findings included: Review of the resident face sheet revealed, Resident #50 was a [AGE] year-old male that admitted to the facility on [DATE]. The face sheet revealed Resident #50 had diagnoses that included, cerebral palsy, mild intellectual disability, auditory hallucinations, schizophrenia, and legal blindness. Review of the MDS dated [DATE] revealed, Resident # 50 had a BIMS (brief interview of mental status) of a 14, which indicated no memory impairment. The MDS also indicated Resident #50 had 1-3 days of physical and verbal behaviors during the assessment period. Resident # 50 required extensive assist for bed mobility, transfer, and toileting. Record review of care plan dated 6/22/2022 indicated behaviors of Resident # 50 included the refusal of ADL care, thinking his remote is a cell phone, and becoming upset when redirected and masturbating in front of staff. Interventions for Resident #50's behaviors were to approach in a calm manner and provide a calm environment. Review of physician orders for June 2022 indicated the following: June 2022: -Seroquel 300mg twice daily-Start date 11/27/2019 -Seroquel 400mg at bedtime-Start date 3/14/2021 During an interview on 8/3/2022 at 2:30PM, Resident #30 informed the survey team that an incident occurred on 7/3/2022 with Resident #50 and LVN A. Resident #30 stated Resident #50 had been hollering about being able to get up but there were no CNAs on the back hall that day. The nurse finally went to get Resident #50 up after he had been yelling out to get up for hours. Resident #50 continued to scream and kick the wall even after they got him up. LVN A took Resident #50 and locked him in the room across the hall from his room. LVN A shut the door on Resident #50, and he screamed, knocked into things in the room for an hour or more screaming for them to let him out. LVN A then took Resident #50 and wheeled him to the secure unit and told him he would stay there until he calmed down. Resident #30 stated she never felt threatened or endangered by the behavior of Resident #50. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	On 8/3/2022 at 2:45 PM the Administrator was notified of an allegation of mistreatment of the Resident #50 on 7/3/2022. During an interview on 8/4/2022 at 11:10am, Resident #52 revealed he was the roommate of Resident #50 on 7/3/2022 when Resident #50 was hollering out to get up. Resident #52 stated on the morning of 7/3/2022 it was announced by LVN A several times, there was no CNA on the back hallway and Resident #50 had been asking for a while that morning to get out of bed. Resident #52 continued, Resident #50 does not have the mental capacity to understand there was no one to get him up and Resident #50 was like a small child mentally. Resident # 50 cried out to get up. That went on for almost 2 hours, then Resident #50 started getting louder and shaking the bed and kicked over his bedside table. Resident #52 stated LVN A and a medication aide came in and told him to cut it out or he was going to lock down. Resident #52 stated he knew Resident #50 feared the lockdown unit because he would say 'no no no' and was quiet for 15 or 20 minutes after LVN A threatened Resident # 50 that he would be put back there. LVN A came back in around lunch time when Resident #50 began screaming out again and told Resident #50 that was it, he was getting locked up. LVN A and the medication aide got Resident #50 up and put him in his wheelchair and rolled him into the room across the hall from their room and shut the door. Resident #50 was in there for an hour or two at the most and began to tear the room up. Resident #52 recalled being able to hear him kicking and hitting things in the room. LVN A pulled Resident #50 from the room and wheeled him backwards down the hallway while he was screaming no, no, no and put him in the locked down unit. Resident #52 said the entire day was chaotic on the back hallway. When Resident #50 returned from the lock down unit he was calm as a kitten. Resident #52 stated it was after supper that Resident #50 returned to his room. Resident #50 slept in his chair until they put him in the bed a few hours later. Resident # 52 stated he never felt scared or threatened by the behaviors of Resident # 50. During an interview with CNA E on 8/4/2022 at 2:20 PM, she revealed that Resident # 50 was brought back to the secured unit or lock down as staff called it, just before lunch time. Resident # 50 ate lunch and supper on the secured unit. CNA E stated she was instructed by LVN A to keep Resident #50 insight because of aggressive behaviors. CNA E stated, Resident #50 called out a few times but was not acting out while he was on the secured unit. CNA E stated the lock down unit had been used a few times in the past to calm residents down. CNA E stated she had not been trained specifically on deescalating people with behaviors but that she did know that you should just leave the resident alone if they are upset. CNA E responded that being brought to a 'lock down' unit against your will could be frightening and cause stress to the residents that have experienced it. CNA E stated Resident #50 was not physically or verbally aggressive while on the lock down unit. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/4/2022 at 8:45am, LVN A revealed she was the nurse on duty on 7/3/2022 and was assigned to Resident #50 and the back hall and secured unit. LVN A stated that Resident #50 was screaming and kicking because he wanted up. LVN A revealed there was just not enough staff to get Resident #50 out of bed as quickly as he wanted. She revealed that she and Medication Aide D got Resident #50 up and he began showing physical and verbal aggression by kicking over his bedside table and screaming. LVN A stated there was not enough staff to watch him, so she put him in the room across the hall from him that was empty. LVN A stated she did not close the door. She stated Resident #50 just stayed in the room with the door open and Resident #50 began tearing the room up by running into the wall and tearing the blinds down. Resident #50 attempted to throw himself out of the wheelchair and into the floor. LVN A stated that she and Medication Aide D attempted to calm Resident #50, but he would not calm down. LVN A stated she and Medication Aide D wheeled him to the behavioral unit so that the CNA E could watch after him until he calmed down. LVN A instructed CNA E to watch Resident #50 until he calmed down. LVN A stated about 3 hours later Resident # 50 calmed down and LVN A let Resident #50 out to go back to his room. LVN A stated, Resident # 50's behaviors were reported to the psychologist the next day on 7/4/2022 and medication adjustments were made. LVN A stated she did not at the time feel like her actions were inappropriate or could be considered abuse of any type to put Resident #50 in a room alone or on the unit to calm his behavior. LVN A stated looking back on it now, she should have taken Resident #50 to the nurse's station and sat with Resident # 50 for a while to calm down or called the MD for medication to calm Resident # 50 down that day. Review of the progress note written by LVN A dated 7/3/2022 11:26 am revealed: resident destructive, throwing things around the room, pulling on blinds, and pushing over tables, resident verbally and physically aggressive toward staff, redirected and assisted up to wheelchair, resident continued to yell and curse at staff and attempted to pull down blinds. Review of the progress note written by Psychologist B dated 7/4/2022 at 12:54PM revealed: Resident #50 was seen for a follow up. Records and reports from other residents and staff indicated that Resident #50 had been aggressive and destructive lately .he suffers from serious schizoaffective disorder and low intellect, and lately it appeared that he underwent some psychiatric decompensation. He was provided counseling to help him stop any form of aggression, follow staff's recommendations, and engage with others in a calm and pleasant manner. Review of progress notes written by LVN C on 7/4/2022 at 1:25pm revealed: New orders per NP K per psych PHD B recommendations to decrease Seroquel to 200mg orally twice daily, add Ativan 0.5mg orally twice daily, add Lexapro 20mg orally once a day. Review of Resident #50 physician orders dated July 2022 indicated the following: -Ativan 0.5mg twice daily- Start date 7/5/2022; Stop date 7/14/2022 -Ativan 0.5mg once daily- Start date 7/15/2022 -Lexapro 20mg once daily- Start date 7/5/2022; Stop date 7/14/2022 -Seroquel 300mg twice daily- Start date 11/27/2019; Stop date 7/5/2022 -Seroquel 400mg at bedtime-Start date 3/14/2021; Stop date 7/4/2022 (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	-Seroquel 400mg twice daily- Start date 7/4/2022 Review of progress notes written by LVN C on 7/8/2022 at 11:28 AM revealed: Day 5 new order per NP K per psych PHD B recommendations decrease Seroquel to 200mg orally twice daily, add Ativan 0.5mg orally twice daily, and add Lexapro 20 mg once a day. Resident has been noted sleeping a lot since med changes, slept through breakfast and ate only small bites of lunch due to sleeping in a wheelchair, to continue to monitor for tolerance of med changes. During record review of the EHR on 8/4/2022 at 2:30 PM the following information was revealed: -no incident report was noted -no documentation was noted about the isolation of Resident #50 in the room across the hall from his room or the secured unit -no notification of the family, administration, or MD on the 7/3/2022. -no other interventions for behaviors documented in Resident #50's chart. During an interview on 8/4/2022 at 4:00 PM, Resident #50 stated yes when asked if he remembered being put in a room with the door closed and then put on the lock down unit about a month ago. Resident # 50 responded, she closed me in that room. Resident #50 agreed that he knocked over a bedside table and torn the blinds up. Resident #50 stated they would not let me up. Resident #50 responded yes when asked if he was scared of lock down. Resident # 50 responded mean people back there. Resident # 50 stated I will be good now. During an interview on 8/4/2022 at 5:30 PM the DON stated that she had no idea Resident #50 had behavioral issues or that the staff put him in a room and closed the door, then put him on the secured unit to calm down. The DON stated it was not in the facility policy to ever seclude residents as a means of behavior modification. The DON stated involuntary seclusion could lead to psychological damage and move behaviors. The DON stated the first time she heard of the incident was when the state surveyor reported it the day prior. During an interview on 8/4/2022 at 9:50 PM, the Administrator stated abuse and involuntary seclusion are not tolerated and everyone had been educated on the chain of reporting. The Administrator stated putting Resident #50 in isolation as a form of punishment would not be tolerated. The Administrator stated she did not know the isolation occurred. Seclusion can make a resident feel threatened and scared. It can make them not trust the staff and have decreased quality of life. LVN A was suspended. The investigation remained underway upon exit. Review of the facility's abuse policy dated 02/01/21 reflected the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, and physical and chemical restraint not required to treat the resident's symptoms, involuntary seclusion, and corporal punishment. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's involuntary seclusion policy dated February 2021 reflected: as part of the abuse prevention strategy, volunteers, employees, and contractors hired by this facility are expected to be able to identify involuntary seclusion and or unauthorized restraint of residents. Involuntary seclusion is defined as a separation of a resident from other residents or from his or her room or confinement to his or her room with or without roommates against the residents will. Examples of involuntary seclusion include: any attempt to keep a resident confined to certain area by blocking the exit with furniture or a closed door; placing a resident in an area without access to a call light or other method of direct communication with staff; placing a resident in a locked or secure unit of the facility without meeting the criteria for the unit; or confining a resident to his or her room for punishment or staff convenience. Secluding or confining a resident against his or her will is prohibited.

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46299 Based on observation, interview and record review, the facility failed to fully investigate, prevent and correct an alleged violation of abuse for 2 of 18 residents reviewed for alleged violations. (Resident #29 and Resident #49) The facility did not thoroughly investigate and correct an allegation of abuse that resulted in Resident #29 being bitten by a CNA, incorrectly unconfirmed abuse, and allowed alleged perpetrator to continue working with residents in the facility. The facility did not throughly investigate and correct an allegation of verbal abuse by TCNA O when she used derogatory lanuage towards Resident #49. These failures could place residents at risk for poor investigations, further allegations of abuse and actual abuse. Findings included: 1. A record review of face sheet and current physician orders dated 07/01/22 indicated Resident #29 was born on 10/06/58 (age 63) and was admitted to this facility on 11/06/21. The resident had diagnosis including a history of mental/mood/behavioral disorders, Major Depressive Disorder and Dementia (the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities). Record review of the 06/04/22 Quarterly MDS assessment indicated Resident #29 was understood and had a BIMs of 06, indicating severely impaired cognition at times. She did reject care for 4 to 6 days of the 7-day review period. She required supervision set-up only for walking. Record review of the 11/06/21 Comprehensive Care Plan revealed for Resident #29 staff must maintain a calm environment and approach. Record review of complaint intake #360678 and facility investigation dated 06/29/22 indicated the incident was reported on 06/28/22, revealed TCNA O bit Resident #29 on the thigh during an altercation, which also resulted in a scrape on Resident #29s left elbow. TCNA O was suspended during the investigation, a police report was completed, a staff in-service on abuse was completed and the completed investigation was faxed to the state on 07/04/22 with the allegations noted as unconfirmed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Record review of the Police Department Case #P2200955 dated 06/28/22 at 08:31 AM revealed assault against elderly or disabled individual (Resident #29). TCNA O physically assaulted Resident #29 after she wanted to call family member around 10:00 PM and staff would not allow it. TCNA O came into the resident's room, sat on her bed and hit her. TCNA O entered Resident #29s room again, jumped on her bed and hit her with her fists, causing the resident to become unconscious at times; also told Resident #29 she was in a mental institution. Then when the resident said she would report TCNA O to administration, both fell off the resident's bed and hit the tile floor, the resident wrapped her thighs around TCNA Os neck and then the TCNA bit the resident on the thigh. TCNA O then hit the resident again in the face with closed fists and left the room. Resident #29 had an injury to her left elbow with a band aid covering it with blood on it, her shirt and sheets, but her right thigh did not have teeth marks. TCNA O was read her [NAME] Rights. Due to the fact that TCNA O is an employee with the nursing home and was working in the Mental health side of the facility she has the duty to protect and care for the residents who she oversees. TCNA O did not show restraint verbally or physically to Resident #29 due to being upset with the threat of being reported to administration. Resident #29 is a [AGE] year-old fragile elderly woman who could not protect herself against a healthy young [AGE] year-old TCNA. The nursing home did not call for police when this assault occurred, they called 9 hours after the assault to report this to the police. Record review of the CPS/APS Intake Report dated 06/28/22 revealed Resident #29 resides at facility and had been physically assaulted three times by TCNA O working overnight. between 11:00 PM and 01:00 AM. TCNA O had bit the resident on her inner right thigh with her teeth and punched her multiple times with a closed fist causing the resident to lose consciousness. A wound to Resident #29s left elbow was band aided over and still had bleeding noted. TCNA O was suspended, and a report was filed for assault against elderly or disabled individual. Record review of the facility staffing schedules 07/01/22 to 08/02/22 revealed TCNA O worked at least 20 shifts at the facility since the abuse to Resident #29. During an interview on 08/02/22 at 04:48 PM with Resident #29, stated she went down the hallway, and asked TCNA O to talk/call to her family member, and the staff would not let her. I tried to open doors and pulled the fire alarm to get the employees attention. TCNA O asked me to go to my room. So, I did. But I still wanted to call my daughter. TCNA O came into my room, jumped on my bed, saying this was a mental institution. I told her (TCNA O) no, this was a place for the elderly. She came back in my room more than once; I said some things and she said, don't talk to me. I threw a bottle hard at TCNA O that missed her because she kept getting near my face, so I pulled her hair and we both fell to the floor, and then TCNA O did bite me on my thigh. I was in fear for my safety with her working here, none of that had to happen if they would have let me call my family member none of that would have happened. She kept coming back in my room, antagonizing me and then left the building. I had an injury to my left elbow that bled and a bite mark on one of my thighs. I filed a police report and staff talked to me about the incident. I thought TCNA O was fired because she should not treat residents that way. Nothing like that had ever happened before that incident at the facility. In an attempted telephone interview with TCNA O on 08/02/22 at 04:58 PM revealed message call cannot be completed due to the called party is unavailable. During an interview on 08/03/22 at 09:00 a.m., with the Administrator and DON, they were asked if they could get ahold of TCNA O. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/03/22 at 05:37p.m., the Regional Nurse reported she made attempts to reach TCNA O all day and were unsuccessful. The facility eventually had contact with TCNA O on 08/04/22 and she gave her notice of termination. During an interview on 08/02/22 at 04:49 PM, CNA CC revealed he stated he was there during the incident with Resident #29 and TCNA O. It was a verbal confrontation between Resident #29 and TCNA O, it then became physical from what I heard, and then when TCNA O went back into the room with Resident #29, I went back to the unit for security reasons. Resident #29 said that TCNA O had bit her, and there was a bite mark on Resident #29s leg. I had abuse training prior to this incident, in-services, and have been a CNA for [AGE] years, I have learned some things. He did not feel TCNA O was abusive towards the resident, even after hearing what took place. Interviews on 08/03/22 at 12:24 PM with LVN F, revealed she stated I worked the night shift on whatever night the incident between Resident #29 and TCNA O occurred, and at approximately 10:00 PM or later, I got back from my break and RN DD and CNA CC were back in the secured unit. TCNA O was the aide on the secure unit and had left the facility after an incident with Resident #29 without telling staff what happened. Resident #29 said she and TCNA O had exchanged words, ended up on the ground, Resident #29s legs around the aide's neck, and the aide bit her. LVN did note a circular red mark on Resident #29s right thigh near her pelvis, but she did not chart a skin assessment. TCNA O was not at work for a while after that incident. She called the DON after that to report what happened. LVN F stated I had abuse training prior to the incident and definitely after the incident. Resident #29 had never been aggressive to any staff physically; this was not like her, so I settled her down and made sure she felt safe, because TCNA O was gone from the building, and she had no other issues that night. LVN F stated allowing the residents to call her family member maybe would have helped prevent this whole incident, she may have asked TCNA O to call her family member, I do not know. During an interview on 08/03/22 at 02:57 PM with the Police Officer revealed that night (06/27/22) around 11:30 PM on the secured unit at the facility, TCNA O said Resident #29 could not call her family member at night. This upset the resident and so she pushed on alarmed doors to irritate the staff. The resident was just upset, saying she wanted to report TCNA O, and TCNA O was mad that Resident #29 was going to report her. The resident had gone to her room, and TCNA O came into her room, sat on her bed. The resident wrapped her legs around TCNA O's neck, they both fell to ground and TCNA O bit her leg. Resident #29 was protecting herself she said, that was why she protected herself. The resident's elbow was busted open, black, blue and purple and there was dried blood on her bedding and clothing. I took pictures of the teeth marks on her leg/thigh, and TCNA O admitted she had punched Resident #29 in the face and bit her. The facility should have called the police right away when it happened so we could have taken Resident #29 to the hospital to get checked out. TCNA O should have never been seated on the resident's bed, antagonizing her. Resident #29 was with it, she remembered everything. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/02/22 at 5:00PM, the Administrator stated she was aware of the incident from the DON that morning after the incident between TCNA O and Resident #29 and reported it. It happened because the staff would not allow the resident to call her family member. This upset the resident and she acted out, pulling the fire alarm for attention. It was reported by TCNA O that Resident #29 attacked her, kicked her causing them to fall to the floor. The resident wrapped her legs around the NAs neck and TCNA O bit the thigh of the resident for her to release. The Administrator stated the facility had trained their employees on de-escalation of combative residents and TCNA O should have left the resident alone and allowed her to call her family member to calm the resident down. TCNA O just worked the front hall instead of the secured unit after the incident. During an interview on 08/02/22 at 5:00PM, the Corporate RN stated police had come out and read TCNA O her [NAME] rights, so the facility thought that meant she had to be terminated. TCNAs references and background check were fine, that is why she was hired. Not firing her could affect every resident in the facility she had contact with after this incident by allowing further abuse. During an interview on 08/16/22 at 01:04 PM, the DON stated I got a call from LVN F about the incident that morning and reported it to the Administrator right away. During an interview on 08/03/22 at 02:57 PM with the Police Officer who was dispatched to this incident revealed that night around 11:30 PM on the secured unit at the facility, TCNA O said Resident #29 could not call her family member at night. This upset the resident and so she pushed on alarmed doors to irritate the staff. The resident was just upset, saying she wanted to report TCNA O, and TCNA O was mad that Resident #29 was going to report her. The resident had gone to her room, and TCNA O came into her room, sat on her bed. The resident wrapped her legs around TCNA O's neck, they both fell to ground and TCNA O bit her leg. Resident #29 was protecting herself she said, that was why she protected herself. The resident's elbow was busted open, black, blue and purple and there was dried blood on her bedding and clothing. The office said he took pictures of the teeth marks on her leg/thigh, and TCNA O admitted she had punched Resident #29 in the face and bit her. He said the facility should have called the police right away when it happened so we could have taken Resident #29 to the hospital to get checked out. TCNA O should have never been seated on the resident's bed, antagonizing her. Resident #29 was with it, she remembered everything. 2. Record review of the face sheet dated 8/2/22 revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis (a disease that impacts the brain, spinal cord, and optic nerves), need assistance with personal care, schizoaffective disorder, bipolar type (a chronic mental health condition that involves symptoms of both schizophrenia and a mood disorder), anxiety disorder, and depression. Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance to total dependence for ADLs. Record review of an undated care plan revealed Resident #49 exhibited verbally abusive behavioral symptoms. Interventions included ignore resident's verbal abuse when directed at you and refocus conversation when resident becomes verbally abusive. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/3/22 at 11:49 a.m., Resident #49 stated he and a staff member exchanged words one day. He said it made me mad and sad because she talked about his mother, and she was his best friend. During an interview on 8/2/22 at 4:23 p.m., Resident #30 said last month, TCNA O cursed out a resident because Resident # 49 threw a tray at her. Resident #30 said I could hear her all the way down to my room and she talked about his momma and dad. She stated TCNA O said, Your mom is bitch and Your dad is a __ and my auntie works here. She said TCNA O was CNA N's niece. During an interview on 8/3/22 at 2:30 p.m., Resident #30 said a verbal altercation between a resident and a CNA happened. She said the altercation was so loud, staff from the front of the building came to the back to see what was happening. She said she was not sure what occurred, but TCNA O cursed a resident down the hall and talking about his mom was a whore and stated, she was going to lose her job today. She said TCNA O cursed the resident out. During an anonymous interview on 8/1/22 at 11:00 a.m., AR said 2-3 weeks ago, he/she heard an aide cursed out a resident. AR said the resident threw his tray and the aide screamed, your mom is a bitch. AR said it happened on 07/03/22. AR said he/she did not know who the resident or aide were. During an interview on 8/3/22 at 10:03 a.m., TCNA L said on 07/03/22, TCNA O did curse out Resident #49. She said the facility was short staffed that weekend and TCNA O came to the back hall to help. She said TCNA O went into Resident #49's room to drop off his lunch tray and screaming started. She said Resident #49 did not throw a plate at TCNA O, put tossed the plate cover on the floor and it did not touch her. TCNA L said her and LVN A pulled TCNA O out of the room and told her to go outside. TCNA L said she told CNA N, the CNA supervisor, about the verbal altercation. She said she had received abuse training upon hire. During an interview on 8/4/22 at 8:45 a.m., LVN A said a loud altercation happened between TCNA O and Resident #49 on 07/03/22. She said Resident #49 threw the lid to the plate and it almost hit TCNA O. TCNA O then cursed Resident #49 and screamed at her aunt who worked here and stated she would lose her job today. LVN A said she attempted to deescalate the situation by separating TCNA O from Resident #49 and told her to go outside for a while then back to the front hall. LVN A said the CNA N showed up at the facility and took TCNA O outside. LVN A said she did not see TCNA O for the rest of the day. She was not sure if TCNA O went home or just stayed down on the front hall. LVN A said she did not assess Resident #49 after the altercation, physically or mentally. LVN A said she felt the altercation was verbal abuse. LVN A said because the on-call nurse and CNA N, who was the CNA supervisor, were in the building they would report the abuse to the administrator. During an interview on 8/3/22 at 5:43 p.m., LVN C said Resident #57 told him about a ruckus that happened over the weekend. He said Resident #57 attempted to play a recording, but it was not working properly. LVN C said he could hear people screaming at each other, but he only heard it for a few seconds. He said Resident #57 said he did not know who was in the recording, but they created a big ruckus. LVN C said he called the administrator on 07/04/22 and told her about the recording because he felt obligated to notify her in case it was verbal abuse. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/3/22 at 10:37 a.m., CNA N said TCNA O and Resident #49 did have an altercation on 07/03/22. She said TCNA O called her and told her about it. She said TCNA O told her Resident #49 threw a plate at her and called her out of her name. She said she told her to leave, and she could not talk to residents like that even if they call you the N word. She said on 07/04/22, LVN C told the Administrator about a recording Resident #57 had on his phone, but he could not hear enough to decipher who it was. LVN C told the administrator Resident #57's phone was not acting right but he felt like she should look into it. CNA N said the Administrator called her to investigate the recording Resident #57 had. She said she asked Resident #57 to listen to the recording he told LVN C about, but he said he did not have it. She said since I could not hear the recording, then there was nothing to investigate. She said the altercation between TCNA O and Resident #49 was abuse. She said TCNA O did not have sufficient abuse and deescalating training before hire. She said the facility was so short staffed when she started, we just need her to work and did not have time to give her sufficient training. She said she did not fire TCNA O because she asked other residents about her care, and no one complained and some even requested her to work on their hall. She said she asked staff about her behaviors, and no one complained. During an interview on 8/3/22 at 12:45 p.m., the Administrator was notified by this surveyor and the team lead of the survey, of reports from staff and residents, verbal abuse had occurred between a resident and staff. The Administrator was also notified of reports from staff, she was notified of the verbal altercation prior to the survey. The Administrator denied any knowledge of abuse in the facility. During an interview on 8/4/22 at 5:40 p.m., the DON said TCNA O's last day worked was 7/31/22. She said she was not told about the incident with Resident #49. She said she was out of town, and no one called her. She said after the first incident with, she did in-service on the prosperity unit, and asked staff about her behavior towards other residents. She said no one complained about her. She said TCNA O was suspended for 2-3 days but disciplinary action was not done. She said she only probably signed the suspension paperwork. She said it should be in her personnel file. During an interview on 8/4/22 at 6:30 p.m., the Administrator said abuse was not tolerated and everyone had been educated on the chain of reporting. She stated she was unaware of the verbal abuse that occurred between TCNA O and Resident #49. She said verbal abuse could make a resident feel threatened and scared. She said it could make residents not trust the staff and have decreased quality of life. Record review of the facility Abuse Prevention Program Policy dated 02/2021 revealed our residents have the right to be free from abuse, including verbal, mental or physical abuse. Our center will protect residents from harm during investigations of all abuse investigations. All reports of resident abuse shall be promptly reported and thoroughly investigated by management.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 44933 Based on interview and record review, the facility failed to ensure assessments accurately reflected the status for 3 of 21 residents reviewed for assessments. (Resident #1, Resident #25, and Resident #10) -The facility failed to code Resident #1 as PASRR (preadmission screening and record review) positive for mental illness. - The facility failed code Resident #25 as a hospice patient on his MDS. - The facility failed code Resident #10 as PASRR positive for mental illness on his MDS. These failures could place residents at risk of not having individual needs met and a decreased quality of life. Findings included: 1. Record review of the face sheet revealed Resident #1 was [AGE] years old, male and admitted on [DATE] with diagnoses including CVA, bipolar disorder, and hemiplegia. Record review of the annual MDS dated [DATE] indicated Resident #1 had a BIMS of 15, which indicated no cognitive impairment. The MDS indicated he required limited assistance with ADLs, and he was not currently considered by the state level II PASRR to have a serious mental illness. Record review of the care plan indicated no care plan for PASRR positive status. During an interview on 8/3/2022 at 2:45pm, the LIDDA (local intellectual and developmental disability authorities) QMHP (qualified mental health professional) assigned to the facility stated that Resident #1 was PASRR positive for mental illness. The QMHP continued to explain that Resident #1 had recently returned from a mental health hospital and she evaluated Resident #1 at that time. Resident #1 denied the services that the PASRR program provided but the PASRR program would meet with him each month for 3 months and then annually, unless Resident #1 went back out to a mental health hospital and the process would start again. The QMHP explained, a denial of services does not mean the resident was not PASRR positive. 2. Record review of the face sheet dated 8/1/22 revealed Resident #25 was [AGE] years old, male, and admitted on [DATE] and readmitted on [DATE] with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conversion disorder (a condition in which a person experiences physical and sensory problems, such as paralysis, numbness, blindness, deafness, or seizures, with no underlying neurologic pathology) with seizures, disorder of brain, and intracranial injury (a sudden trauma causes damage to the brain) without loss of consciousness. Record review of the MDS dated [DATE] revealed Resident #25 was rarely/never understood and rarely/never understood others. The MDS revealed Resident #25 had short-and-long term memory loss. The MDS revealed Resident #25 had severely impaired cognitive skills for daily decision making. The MDS revealed Resident #25 required total dependence for ADLs. The MDS did not reveal Resident #25 was on Hospice care. Record review of Resident #25's undated care plan revealed terminal care (Hospice) with problem start date of 7/16/22. Interventions included comfort measures to provide Resident #25 with assist as needed to maintain dignity and comfort, meds as ordered to ensure pain control, and Hospice consult with a hospice company. Record review of the consolidated physician orders dated 8/1/22 revealed admit to a hospice company for hospice diagnosis of Parkinson's disease on 7/28/22. During an interview on 8/2/22 at 12:26 p.m., Resident #25's hospice nurse said he had been readmitted on their services on 7/28/22. She said he was on their services previously but due to his hospital admission on 7/22/22 he was taken off their services. 3. Record review of the face sheet dated 8/1/22 revealed Resident #10 was [AGE] years old, male, and admitted on [DATE] with diagnoses including schizoaffective disorder (disorder is a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), bipolar type, anxiety disorder, and severe bipolar with psychotic features (a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks). Record review of the MDS dated [DATE] revealed Resident #10 was understood and understood others. The MDS revealed Resident #10 had a BIMS of 14 which indicated intact cognition and required extensive assistance for ADLs. The MDS did not reveal Resident #10 was PASRR positive for mental illness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the care plan dated 7/13/22 revealed Resident #10 had self-care deficit related to quadriplegia as evidence by required assistance with ADLs. The care plan revealed Resident #10 had memory and recall problems related to short term memory deficit. The care plan revealed Resident #10 was at risk for side effects of anti-psychotic drug use due to schizoaffective disorder, bipolar type. The care plan revealed Resident #10 had depression and anxiety related to loss of roles/status. The care plan did not address Resident #10's PASRR positive for mental illness. Record review of the PASRR level I screening dated 12/21/18 revealed Resident #10 had evidence or indicators for mental illness. Record review of the PASRR level I screening dated 1/22/19 revealed Resident #10 had evidence or indicators for mental illness. During an interview on 8/4/2022 at 5:40 PM, the DON stated she was still learning about the process of doing the MDS. The DON stated inaccurate coding on the MDS could affect resident care. The DON stated inaccurate coding on the MDS will make the care plan inaccurate and the care plan was the instructions to resident centered care. The DON stated it was the responsibility of the MDS Coordinator to accurately code all MDS information and it was to be checked by random audits done quarterly by the corporate RN. During an interview on 8/4/2022 at 9:20 pm, the Administrator stated that it was important for the MDS to be correct for the purpose of providing the correct amount and type of care to the resident. Not having a correctly coded MDS could affect the care the resident receives by not receiving the right types of care and services that would allow them to meet their optimal level of existence. Record Review of an undated facility Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy indicated, The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident .According to CMS's RAI Version 3.0 manual; the MDS is a core set of screening, clinical, and functional status elements .which forms the foundation of a comprehensive assessment for all residents of nursing homes .the items of the MDS standardize communication about resident problems and conditions with nursing homes, between nursing homes, and outside agencies .Federal regulations .require that .the assessment accurately reflects the resident's status .

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46299 Based on interview and record review, the facility failed to ensure a baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was implemented for 1 of 18 residents reviewed for new admissions (Resident #59). The facility did not develop a baseline care plan within 48 hours of admission for Resident #59. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of the Admission Face Sheet dated 07/04/22, for Resident #59 revealed a [AGE] year-old male with date of birth of 10/27/50. His diagnoses included Hyperlipidemia (high cholesterol), Post Traumatic Stress Disorder (trauma induced), Depression, Anxiety, Dementia (the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities), Hypertension (high blood pressure), Cerebral Infarction (stroke) and lack of coordination with muscle weakness. Record review of the Admission MDS dated [DATE] documented a brief interview for mental status noting long/short-term memory problems with severely impaired cognitive skills for daily decision making and continuous inattention. Resident #59 had a Total Severity Score of 04, indicating minimal depression. He exhibited physical behaviors directed at others and rejection of cares noted 1 to 3 days. The resident required extensive one to two staff assistance for ADLs. He had 7 days of routine antipsychotics and antidepressants administered and 4 days of antianxiety medications administered. Record review of the 07/04/22 to 08/02/22 Active Physician Orders revealed Resident #59 received Amlodipine (blood pressure medication), Ativan with medication side effect monitoring (anti-anxiety medication), Atorvastatin (cholesterol medication), Depakote (mood medication), Folic Acid (vitamin B), Melatonin (sleep aide), Seroquel with antipsychotic medication monitoring (antipsychotic medication), Sertraline with antidepressant medication side effect monitoring (antidepressant), Thiamine (B1 vitamin), Trazadone with antidepressant medication side effect monitoring (antidepressant), Aspirin (antiplatelet medication) and was on Hospice. Record review of Resident #59s chart for the Baseline Care Plan revealed no care plan completed until 07/22/22. During an interview on 08/02/22 at 4:58 PM with the Clinical Care Manager/MDS Coordinator stated that the ADON, or the DON would be responsible for updating the care plans, and they often updated the care plans during the care plan meetings. During an interview on 08/04/22 at 7:00 PM with the DON, she said the MDS coordinator was responsible for the comprehensive care plan, but herself, the ADON, and any of the nurses could update it when needed. She said residents had the risk of not having their needs met if care plans were not updated. She and the MDS Coordinator ensured the care plans were updated. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/04/22 at 7:30 PM with the Clinical Care Manager/MDS Coordinator, she said she had been employed with the facility for almost 2 years. She said she was just given the task of doing the comprehensive care plan a couple of weeks ago and she knew she needed to audit all the care plans for all the residents and update them. She said she did not feel the resident would be negatively impacted because the staff did not really look at the care plans. During an interview on 08/04/22 at 7:34 PM with the Administrator, she said if the care plans were not updated for all the care areas, the resident could not get the care they needed, wanted, or what was ordered. Record review of the 12/2016 facility Care Plans Baseline Policy revealed a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission to include: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASARR recommendation, if applicable.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44596 Based on observations, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 5 of 21 residents (Resident #1, Resident #8, Resident #10, Resident #34, and Resident #52) reviewed for comprehensive person-centered care plans. The facility failed to care plan Resident #1, Resident #8, and Resident #10 as PASRR (preadmission screening and record review) positive for mental illness. The facility failed to address pertinent care areas on the care plan of Resident #34 and Resident #52. These failures could place residents at risk of not having individual needs met and a decreased quality of life. Findings included: 1.Record review of the face sheet revealed Resident #1 was [AGE] years old, male, and admitted on [DATE] with diagnoses including CVA, bipolar disorder, and hemiplegia. Record review of the annual MDS dated [DATE] indicated Resident #1 had a BIMS of 15, which indicated no cognitive impairment. The MDS indicated he required limited assistance with ADLs, and he was not currently considered by the state level II PASRR to have a serious mental illness. Record review of the PASRR level one indicated Resident #1 was PASRR positive for mental illness. Record review of the care plan dated 7/7/2022 revealed no record to indicate Resident #1 was PASRR positive for mental illness. During an interview on 8/3/2022 at 2:45pm the LIDDA (local intellectual and developmental disability authorities) QMHP (qualified mental health professional) assigned to the facility stated that Resident #1 was PASRR positive for mental illness. The QMHP continued to explain that Resident #1 had recently returned from a mental health hospital and she evaluated Resident #1 at that time. Resident #1 denied the services that the PASRR program provided but the PASRR program would meet with him each month for 3 months and then annually, unless Resident #1 goes back out to a mental health hospital and the process will start again. The QMHP explained, a denial of services does not mean the resident was not PASRR positive. 2. Record review of the face sheet dated 8/1/22 revealed Resident #8 was [AGE] years old, female, and admitted on [DATE] with diagnoses including major depressive disorder, recurrent, mild, Parkinson's, and generalized anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS dated [DATE] revealed Resident #8 was currently considered by the state level II PASRR process to have serious mental illness. The MDS revealed Resident #8 was understood and understood others. The MDS revealed Resident #8 had a BIMS of 14 which indicated intact cognition and required supervision-total dependence for ADLs. Record review of the PASRR level I screening dated 9/29/21 revealed Resident #8 had evidence or indicators for mental illness. Record review of the PASRR level I screening dated 7/8/22 revealed Resident #8 had evidence or indicators for mental illness. Record review of the care plan dated 6/22/22 revealed Resident #8 had impaired decision making related to diagnosis of Parkinson's with dementia. The care plan did not address PASRR positive for mental illness. 3. Record review of the face sheet dated 8/1/22 revealed Resident #10 was [AGE] years old, male, and admitted on [DATE] with diagnoses including schizoaffective disorder (disorder is a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), bipolar type, anxiety disorder, and severe bipolar with psychotic features (a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks). Record review of the MDS dated [DATE] revealed Resident #10 was understood and understood others. The MDS revealed Resident #10 had a BIMS of 14 which indicated intact cognition and required extensive assistance for ADLs. The MDS did not reveal Resident #10 was PASRR positive for mental illness. Record review of the PASRR level I screening dated 12/21/18 revealed Resident #10 had evidence or indicators for mental illness. Record review of the PASRR level I screening dated 1/22/19 revealed Resident #10 had evidence or indicators for mental illness. Record review of the care plan dated 7/13/22 revealed Resident #10 had self-care deficit related to quadriplegia as evidence by required assistance with ADLs. The care plan revealed Resident #10 had memory and recall problems related to short term memory deficit. The care plan revealed Resident #10 was at risk for side effects of anti-psychotic drug use due to schizoaffective disorder, bipolar type. The care plan revealed Resident #10 had depression and anxiety related to loss of roles/status. The care plan did not address Resident #10's PASRR positive for mental illness. 4. Record review of a face sheet dated 8/1/22 revealed Resident #34 was a [AGE] year-old male that admitted to the facility on [DATE] with the diagnoses of multiple sclerosis (nerve damage that disrupts the communication between the brain and the body), acute and chronic respiratory failure (difficulty breathing and the lungs do not get enough oxygen), hypertension (high blood pressure), pneumonia (infection that inflames the air sacs in the lungs and may be filled with fluid or pus), malnutrition (the body does not get enough nutrients), Stage 4 pressure ulcer (wound caused by pressure that has loss of tissue and exposed muscle or bone), and history of coronavirus 2019. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an admission MDS dated [DATE] indicated Resident #34 was unable to complete the BIMS. Resident #34 was total dependent and required the assistance of two persons for all ADLs. Resident #34 was always incontinent (unable to control) of bowel and he had a foley catheter (tube into the bladder to drain urine). Resident #34 had a tracheostomy (direct airway into the trachea (windpipe) through a surgical incision in the neck). Resident #34 was unable to communicate with others. Resident #34 had diagnoses of anemia (a condition where the blood does not have enough healthy red blood cells), hypertension (high blood pressure), GERD (gastroesophageal reflux disease-digestive disease in which stomach acid flows into the food pipe and irritates the lining), pneumonia, malnutrition, acute and chronic respiratory failure, stage 4 pressure ulcer, and osteomyelitis (infection of the bone) of sacral and sacrococcygeal region (bottom of the spine and the tailbone). Resident #34 had three stage 2 pressure ulcers (wound caused by pressure with loss of the top two layers of skin). Resident #34 had one unstageable pressure ulcer (wound caused by pressure and the extent of the wound could not be visualized). Resident #34 had a pressure reducing mattress on his bed. Resident #34 had a feeding tube (tube placed into the stomach to provide nutrition). Record review of Resident #34's care plan with admitted [DATE] revealed it did not address the resident's multiple disease processes of anemia, hypertension, GERD, pneumonia, malnutrition, acute and chronic respiratory failure, stage 4 pressure ulcer, and osteomyelitis of sacral and sacrococcygeal region. Resident #34's care plan revealed it did not address the resident's pressure ulcers or risk of developing additional pressure ulcers. Resident #34's care plan revealed it did not address the resident had a feeding tube or the care of the feeding tube. Resident #34's care plan revealed it did not address he had a tracheostomy or the care of the tracheostomy. Resident #34's care plan revealed it did not address ADL care/assistance needed, incontinence of bladder, the presence of a foley catheter, or the care of the foley catheter. Resident #34's care plan did not address the resident's contractures (permanent tightening of the muscles, tendons, and skin that cause the joints to shorten and become very stiff) and limited mobility. Record review of Resident #34's physician order report dated 7/01/22-7/31/22 revealed orders for feeding tube care, when to check the feeding tube for correct placement, what kind of feeding and what rate the resident was to be fed. The orders included when to perform tracheostomy care, wound care for multiple pressure ulcers, and medications for hypertension, pain, infections, GERD, anemia, contractures, and respiratory medications. There were no orders related to the resident's foley catheter. During observations on 8/1/22 at 11;53 AM revealed Resident #34 had a tracheostomy, feeding tube, and a foley catheter bag. 5. Record review of a face sheet dated 8/04/22 revealed Resident #52 was a [AGE] year-old male that was admitted [DATE] with the diagnoses of arthritis (joint pain) of right shoulder due to bacteria, infection of right shoulder, left knee pain, diabetes (disease where there is too much sugar in the blood), bipolar (disorder with episodes of mood swings ranging from depressive lows to manic highs), anxiety (intense, excessive, and persistent worry and fear about everyday situations), hypertension, coronary heart disease (damage or disease in the heart's major blood vessels), chronic obstructive pulmonary disease (disease of the lungs that block airflow and make it difficult to breathe), fracture of right upper arm, MRSA (methicillin resistant staphylococcus aureus) infection, reduced mobility, need for assistance with personal care, and pain in right shoulder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an admission MDS dated [DATE] indicated Resident #52 had a BIMS of 15, which indicated he was cognitively intact. Resident #52 required extensive assistance of one to two person for most ADLs, except was total dependent on two persons for bathing. He required supervision and assist of one person for locomotion and eating. He used a wheelchair for mobility. Resident #52 was occasionally incontinent (no control) of urine and frequently incontinent of bowel. Resident #52 had diagnoses of anemia, hypertension, coronary artery disease, diabetes, anxiety, bipolar, chronic obstructive pulmonary disease, fracture of right upper arm, and arthritis. Resident #52 had frequent pain and had a history of fall with injury. Resident #52 was at risk for developing pressure ulcers and he had a surgical wound. Resident #52 was receiving antipsychotic, antibiotic, opioid, and intravenous (in the vein) medications. Resident #52 was receiving occupational and physical therapy at the facility. Record review of the Resident #52's care plan with admitted [DATE] revealed it did not address the resident's multiple disease processes of anemia, hypertension, coronary artery disease, diabetes, anxiety, bipolar, chronic obstructive pulmonary disease (COPD), fracture of right upper arm, and arthritis. Resident #52's care plan did not address he was receiving intravenous (IV) antibiotics through a PICC line (peripheral inserted central catheter-tube inserted in a vein in an arm or leg, used for long-term intravenous medications) or care of the PICC line. Resident #52's care plan did not address assistance needed for ADLs or he was incontinent of urine and bowel. Resident #52's care plan did not address he had an infection, limited range of motion to right shoulder, or pain. Record review of Resident #52's active orders not dated revealed he was on medications for diabetes, bipolar, coronary heart disease, anemia, hypertension, pain, infection, COPD, PICC line flushes, and monitor for anxiety. During an observation on 8/01/22 at 11:37 AM revealed Resident #52 had a PICC line covered with a clear dressing and an IV pole with an empty Naficillin (antibiotic) bag with tubing hanging on the pole. During an interview on 8/4/22 at 12:51 p.m., the mental health QMHP said Resident #8 and Resident #10 were PASRR positive. She said even if Resident #8 denied services, she was still PASRR positive. During an interview on 8/4/2022 at 5:40PM the DON revealed she did not know a lot about the MDS or the PASRR process. The DON stated she was still learning. The DON was not aware of special benefits for PASRR positive residents. During an interview on 8/4/22 at 6:30 p.m. the Administrator said accuracy of assessments and care plan were important. She said that was how the facility got paid and how the staff knew what kind of care they needed. She said, if they were not done accurately, you risk the residents not receiving the care they require for a quality of life. During an interview on 8/4/22 at 6:40 PM the Administrator revealed she was aware of special benefits for PASRR positive residents. The Administrator was not certain why the MDS nurse did not care plan Resident #1 as PASRR positive. The Administrator revealed having a correct care plan was important so that each resident gets the individual care they need. The Administrator revealed if the care plan was not accurate some aspects of care can be missed by staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/04/22 at 7:00 PM with the DON, she said the MDS coordinator was responsible for the comprehensive care plan, but herself, the ADON, and any of the nurses could update it when needed. She said residents had the risk of not having their needs met if care plans were not updated. During an interview on 8/04/22 at 7:30 PM with the Clinical Care Manager, MDS coordinator, she said she had been employed with the facility for almost 2 years. She said she was just given the task of doing the comprehensive care plan a couple of weeks ago and she knew she needed to audit all the care plans for all the residents and update them. She said she did not feel the resident would be negatively impacted because the staff did not really look at the care plans. During an interview on 8/04/22 at 7:34 PM with the Administrator, she said if the care plans were not updated and included all the care areas, the resident could not get the care they needed, wanted, or what was ordered. Record review of the facility's care plan policy titled Care Plans, Comprehensive Person-Centered dated 12/2020 revealed, .a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . the comprehensive, person-centered care plan will: include an assessment of the resident's strengths and needs, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment, describe any specialized services to be provided as a result of PASRR recommendations, resident's stated goals upon admission and desired outcomes, residents stated preference and potential for future discharge, incorporate identified problem areas . aid in preventing or reducing decline in the resident's functional status and /or functional levels . identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process . comprehensive person-centered care plan is developed within seven days of the completion of the required comprehensive assessment . assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change . 46062

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46299 Based on interview and record review, the facility failed to revise the comprehensive care plan of each resident to meet a resident's nursing needs for 1 of 18 residents reviewed for care plans (Residents #16). The facility failed to update the comprehensive care plan with ambulatory assist status for Resident #16 after completing therapy. This failures could place residents at risk of not having their individualized goals and needs met, inhibiting independence. Findings included: A 08/02/22 face sheet with current physician orders indicated Resident #16 was age 85 and admitted to this facility on 01/19/22. The resident had diagnosis including Dementia (the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities) and reduced mobility. Record review of the 05/18/22 Quarterly MDS assessment revealed a BIMS of 03, indicating severely impaired cognition. He required limited one staff assistance with walking: gait stable only with staff assistance. He completed physical therapy starting on 05/13/22 for 139 minutes in 3 days of the review period and had at least 15 minutes of therapy for 6 days of the review period. Record review of the 01/19/22 Comprehensive Care Plan revealed revision 06/08/22 noting to give verbal reminders not to ambulate without assistance. Lacked update for ambulation to stand-by assistance only with unsteady gait after goal met in therapy on 07/07/22. Record review of 07/07/22 Therapy Discharge Progress Note revealed Resident #16 was released on 07/07/22 from therapy for meeting goals with updated ambulation status noting stand by assistance only with unsteady gait. Interviews on 08/03/22 at 01:00 PM with CNA E stated Resident #16 was very independent and his gait was steady; he walked a lot on his own. Therapy had been working with him, he was more confident and up walking. Interviews on 08/03/22 at 06:11 PM with LVN F stated Resident #16 was stand-by assistance when unsteady; he was very independent. During an interview on 08/04/22 at 08:55 AM with DOR stated therapy worked with Resident #16 until July 7th and he was released from therapy. He was supervision to standby assistance for walking only when he would have an unsteady gait and he did very well. The goal was to give independence, and he did well. Not updating the care plan after completing his therapy may inhibit a resident's independence. The care plan should have been updated at the next daily interdisciplinary meeting after his release from therapy and change in ambulation status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Requested the facility care plan timing/revision policy from the Administrator and DON on 08/04/22, did not receive policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 46062 Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living with the necessary services to maintain good personal hygiene for 7 (Resident #10, Resident #23, Resident #32, Resident #34, Resident #46, Resident #49, and Resident #57) of 21 residents reviewed for ADL (activities of daily living) care. The facility failed to provide dependent Residents #10, #23, #32, #34, #46, #49, and #57 with scheduled bed bath/showers. The facility failed to provide scheduled bed bath/showers and wash the hair of Resident #10, Resident #49, and Resident #57. The facility failed to provide nail care to Resident #46, #23, #32 and Resident #57. The facility failed to provide shaving to Resident #34 and Resident #46. These failures could place residents who required assistance from staff for personal hygiene at risk of not receiving care and services to meet their needs. Findings included: 1. Record review of the face sheet dated 8/4/22 revealed Resident #10 was [AGE] years old, male, and admitted on [DATE] with diagnoses including muscle wasting and atrophy, and quadriplegia (paralysis of all four limbs). Record review of the MDS dated [DATE] revealed Resident #10 was understood and understood others. The MDS revealed Resident #10 had adequate vision. The MDS revealed Resident #10 had a BIMS of 14 which indicated intact cognition and required extensive assistance for dressing, bed mobility, and transfers. And required total dependence for toilet use, personal hygiene, and bathing. Record review of the care plan dated 7/13/22 revealed Resident #10 had self-care deficit related to quadriplegia as evidence by required assistance with ADLs. Intervention included total x 1-2 assistance with bath/showering 3 times a week. The care plan revealed Resident #10 had episodes of resisting care including showers. Interventions included monitor for early signs of behavior, approach in calm manner, and when refuses care re-approach later, notify nurse to document in chart. Record review of the point of care history dated 5/4/22-8/4/22 revealed Resident #10 received no baths documented in May 2022. In June 2022, Resident #10 received 3 (6/23/22,6/25/22,6/27/22) partial bed baths (bathing the following areas: face, hands, underarms, back, buttocks and genital) and showers (6/24/22, 6/25/22, 6/30) out of 13 days. In July 2022, Resident #10 received 12 partial bed baths (7/1/22,7/3/22, 7/6/22, 7/7/22, 7/8/22, 7/11/22,7/12/22, 7/25/22, 7/26/22, 7/27/22, 7/29/22, 7/30/22) 2 showers (7/5/22,7/23/22), and 1 complete bed bath (7/26/22) out of 13 days. No refusals were documented on the point of care history. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 8/1/22 at 10:30 AM, Resident #10 said he had not had a shower since Wednesday (7/27/22). Resident #10 had greasy hair with dry, white patched noted to his scalp. During an interview and observation on 8/2/33 at 9:30 a.m., LVN C said Resident #10 was transferred to the hospital this morning due to altered mental status. 2. Record review of a face sheet revealed Resident #23 was a [AGE] year-old male, that was admitted to the facility on [DATE] with the diagnoses of anemia (low iron in the blood), hypothyroidism (A condition in which the thyroid gland doesn't produce enough thyroid hormone), and edema (swelling). Record review of an MDS dated [DATE] indicated Resident #23 had a BIMS of 08, which indicated a mild cognitive deficit. Resident #23 required extensive to dependent assistance with ADL. Resident #32 was understood and understood others. Record review of Resident #23's care plan dated 7/27/22 titled ADL care listed an intervention to aid with bathing/showering 3 times per week and a sponge bed bath on non-shower days if needed. During an observation and interview on 8/1/22 at 9:33AM, Resident #23 stated he only got a bath about once every 2 weeks and had not had his hair washed in a couple months. Resident #23's hair was noted to be greasy. There was a strong smell of urine noted when entering the room. When asked if he would like a bath 3 days a week, he stated at least twice a week would be nice since he peed on himself so he could keep his skin clean. Resident #23 was noted to have long dirty fingernails. They were noted to be 3/4 inch from fingertips with a brown substance under all nails. There were yellow stains noted to his pillowcase when he lifted his head. Gray stubble covered Resident #23s face, approximately 1/2 inch long. Resident #23 stated the facility shaved him last week when he got his bath. Resident #23 stated he would like more than one bath a week but not every day. He stated he liked to feel clean it made him feel better. Record review of the point of care ADL report dated 5/26/22-6/30/22, there was documentation of 5 baths being given (6/11, 6/21, 6/23, 6/25, and 6/30). According to the bath schedule Resident #23 should have received 15 baths in this time. No refusals were documented, or care planned for Resident #23. 3. Record review of a face sheet revealed Resident #32 was a [AGE] year-old-male that was admitted to the facility on [DATE] with the diagnosis of CVA (stroke), hemiplegia of dominant side (paralysis on right side of body), and protein calorie malnutrition. Record review of the MDS dated [DATE] revealed Resident #32 was usually understood and usually understood others. Resident #32 was noted to have a BIMS of 04 which indicated a significant cognitive impairment and he required extensive assistance with ADLs such as transfer, bathing, and bed mobility. Record review of Resident #32's care plan dated 6/29/22 titled general had interventions listed for nail care to be done every Tuesday, Thursday, and Saturday on the 6pm to 6am shift. The interventions also listed bathing to occur every Tuesday, Thursday, and Saturday on the 6pm-6am shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/1/22 at 9:33PM, Resident #32 was noted to have a foul odor of ammonia and feces. The resident was observed with dirty long fingernails with thick brown gummy like substance underneath that were 3/4 to 1 inch from the tip of fingers. When asked if he would like a bath, Resident #32 shook his head indicating yes and stated yeah. Record review of Resident #32's point of care ADL report dated 5/26/2022-6/30/2022, revealed there was documentation of 6 baths being given of the 15 baths due during this time frame. No refusals were documented, or care planned for Resident #32. 4. Record review of a face sheet dated 8/1/22 revealed Resident #34 was a [AGE] year-old male that admitted to the facility on [DATE] with the diagnoses of multiple sclerosis (nerve damage that disrupts the communication between the brain and the body), acute and chronic respiratory failure (difficulty breathing and the lungs do not get enough oxygen), hypertension (high blood pressure), pneumonia (infection that inflames the air sacs in the lungs and may be filled with fluid or pus), malnutrition (the body does not get enough nutrients), Stage 4 pressure ulcer (wound caused by pressure that has loss of tissue and exposed muscle or bone), history of coronavirus 2019. Record review of an admission MDS dated [DATE] indicated Resident #34 was unable to perform the BIMS. Resident #34 was total dependent and required the assistance of two persons for all ADLs. Resident #34 was always incontinent (unable to control) of bowel. Resident #34 was unable to communicate with others. Record review of Resident #34's care plan dated 7/22/22 titled General listed an intervention for bathing on Monday, Wednesday, and Fridays on the 6PM-6AM shift. Record review of Resident #34's Point of Care ADL Category Reports from 7/01/22-7/31/22 and 8/01/22-8/04/22 revealed there was no documentation of bathing the resident. During an observation on 8/01/22 at 11:53AM Resident #34 was observed with unkempt white facial hair and dry scaly skin. Resident was non-verbal and unable to care for self. During an observation on 8/01/22 at 5:22PM observed Resident #34's full body during a linen change and wound care and his skin was scaly and dry. Resident #34 had a goatee (hair on his chin) and had approximately 1/2 inch stubble to the rest of his face. During an observation on 8/03/22 at 11:00AM, Resident #34's skin was observed, and it was scaly and dry. Resident #34 had a goatee (hair on his chin) and continued to have approximately 1/2 inch stubble to the rest of his face. 5. Record review of a face sheet dated 8/1/22 revealed Resident #46 was a [AGE] year-old male, that admitted to the facility on [DATE] with the diagnoses of weakness, history of a displaced fracture of left tibial tuberosity (lower leg), glaucoma (the nerve connecting the eye to the brain is damaged from high eye pressure), difficulty sleeping, and coronavirus 2019. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the admission MDS dated [DATE] indicated Resident #46 had a BIMS of 12, which indicated the resident was cognitively intact. Resident #46 required extensive assistance of one to two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene (combing hair, brushing teeth, shaving, washing/drying face and hands). Resident #46 required total dependence of 2 persons for bathing. Record review of Resident #46's care plan dated 7/22/22 titled General listed an intervention of bath/showers on Tuesday, Thursday, and Saturdays on the 6PM-6AM shift. Record review of Resident #46's Point of Care ADL Category Reports from 7/01/22-7/30/22 and 7/31/22-8/03/22 revealed the resident had a bed bath on 7/2/22, a partial bath 7/3/22, bed baths on 7/6/22, 7/7/22, 7/8/22, and a partial bath on 7/26/22. Resident #46 did not receive baths from 7/09/22 through 7/25/22. The bath schedule showed he should have received 3 baths during the week of 7/11/22 and the week of 7/26/22 for a total of six baths, however, he had one partial bath on 7/26/22 during that time. There was no documentation that Resident #46 refused care. During an observation and interview on 8/01/2 at 12:01PM with Resident #46, he said he received his bath in the bed, because he could not stand up. He said he wanted to be shaved, wanted a haircut, and wanted his hands and under his nails cleaned. [NAME] substance observed under all of Resident #46's fingernails and approximately 1/2 inch white facial hair observed on his face and neck. He said he did not receive baths regularly and he had to bang on his bedside table to receive assistance in his room, because his call light was not working. He said a bath with a shave would make him feel better and no one wants to eat with dirty hands and fingernails. During an observation on 8/03/22 at 11:31AM, observed Resident #46 asleep in bed. The resident had approximately 1/2 inch white facial hair to face and neck and brown substance under all his fingernails. During an observation and interview on 8/03/22 at 11:54AM Resident #46 said he did not get a bath last night (Tuesday 8/02/22) and really needed a shave and his hands and fingernails cleaned. Resident #46 continued to have approximately 1/2 inch white facial hair to face and neck and brown substance under all his fingernails During an observation on 8/03/22 at 05:11PM, Resident #46 told CNA BB that he would like a shave and to wash his hands and nails and she told him she would take care of it. During an observation and interview on 8/04/22 at 10:45AM Resident #46 said no one had bathed him yet and he needed someone to shave him and wash his hands and fingernails. Resident #46 was observed to still have approximately 1/2 inch long white hair on his face and neck. 6. Record review of the face sheet dated 8/02/22 revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis (is a disease that impacts the brain, spinal cord and optic nerves, which make up the central nervous system and controls everything we do), need assistance with personal care, and muscle wasting and atrophy (shortening). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance for bed mobility, transfers, and personal hygiene. And total dependence for dressing and bathing. Record review of the undated care plan revealed Resident #49 would have the following tasks documented in POC. Intervention included bath/showers on Tuesday, Thursday, and Saturday on the 6am-6pm shift. Bathing/hygiene assist amount not specified. Record review of the point of care history dated 5/4/22-8/4/22 revealed Resident #49 received one partial bed bath (bathing the following areas: face, hands, underarms, back, buttocks and genital) on 5/22/22 in May out of 13 days. In June 2022, Resident #49 received 8 partial bed baths (6/5/22, 6/16/22, 6/17/22, 6/19/22, 6/21/22, 6/22/22, 6/27/22, 6/29/22), 2 showers (6/23/22, 6/25/22), and 1 complete bed bath (wash the entire body) on 6/30/22 out 13 days. In July 2022, Resident #49 received 3 partial bed baths (7/1/22) and 1 shower (7/2/22) out of 13 days. No refusals were documented of the point of care history. During an interview and observation on 8/1/22 at 10:28 a.m., Resident #49 said he had not had a shower since admission, and they did not wash his hair. He said he was scheduled on the morning shift. He stated, staff leave me in piss and dirty diapers, and I wanted out of this fuckin, nasty place. Resident #49 was lying in bed with greasy hair and large yellow stain on his pillow. Resident #49 chest was stained light brown. 7. Record review of the face sheet dated 8/1/22 revealed Resident #57 was [AGE] years old, male, and admitted on [DATE] with diagnoses including chronic pain syndrome, muscle wasting and atrophy, functional quadriplegia (a person affected by paralysis of all four limbs), and polymyositis (an uncommon inflammatory disease that causes muscle weakness affecting both sides of your body) with myopathy (a disorder of the skeletal muscles). Record review of the MDS dated [DATE] revealed Resident #57 was understood and understood others. The MDS revealed Resident #57 had a BIMS of 15 which indicated intact cognition and required total dependence for ADLs. The MDS revealed Resident #57 rejected evaluation or care 1 to 3 days. Record review of the undated care plan revealed Resident #57 the following tasks will be documented in POC. Interventions included bath/showers and nail care on Tuesday, Thursday, and Saturday on the 6pm-6am shift. Record review of the point of care history dated 5/4/22-8/4/22 revealed Resident #57 received 2 complete bed bath (5/28/22,5/29/22) and 1 partial bed bath (5/31/22) out 13 days in May 2022. In June 2022, Resident #57 received 5 complete bed baths (6/1/22, 6/2/22, 6/3/22, 6/7/22, 6/8/22), 3 partial bed baths (6/4/22, 6/5/22, 6/8/22), and 2 showers (6/3/22, 6/9/22) out of 13 days. In July 2022, Resident #57 had no documentation of bed bath or shower. No refusals were documented on the point of care history. Record review of Resident #57's progress notes dated 7/11/22 -8/1/22 revealed no nursing documentation of bed bath/shower refusals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/1/22 at 11:27 a.m., Resident #57 was lying in bed with a large, yellow stained pillow. Resident #57 had greasy hair, flaky, dry skin to his face with redness noted, and long nails with brown matter underneath. Resident #57 said he had not had his hair washed since he was admitted . He said he sometimes gets bed bath, but they do not wash his hair. He said on 7/31/22, his urinal overflowed on to his sheets and no one came to change his linens for 12 hours. During an interview on 8/1/22 at 11:35 a.m., LVN C said Resident #57 had fungal infection on his face. During an interview on 8/2/22 at 9:41 p.m., CNA H said she was doing the best she could as the only CNA for the back hall (15 residents) and the secured unit (21 residents). She said she had not given any bathes this evening. She said there was no way she could do that by herself. She said it was short staffed 90% of the time. CNA H said occasionally there will be a day they had 4 CNA on night shift. She said she did not feed Resident #57. During an interview on 8/2/22 at 10:30 p.m., the Administrator said the staffing numbers for the facility was to have 5 CNAs on day and night shifts, but she felt the facility ran well with 3 staff members. The Administrator was made aware of having only 2 CNA's this night shift and no showers had been given. During an interview on 8/3/22 at 10:03 a.m., TCNA L said she had been at the facility for a month. She said she normally worked the front and center halls (26 residents). She said residents do not get their scheduled bed baths or showers due to lack of staff. She said if a resident was scheduled for a bed bath or shower on the night shift, it probably was not going to get done. During an interview on 8/3/22 at 10:37 a.m., CNA N said she was the CNA coordinator but also had to work the floors. She said due to lack of staff, residents did not get their scheduled bath/showers, nail care or oral care. She said she tells the CNAs to at least wash the residents face and hands. She said CNAs did not wash resident's hair if they got bed baths. During an interview on 8/4/22 at 6:30 p.m., the Administrator said being short of staff can affect resident care and make them miss baths, grooming, activities, have skin issues, miss medications, and have decreased quality of life. During an interview on 8/4/22 at 7:00PM with the DON, she said the staff nurses were responsible for ensuring the nurse aides were bathing the residents as scheduled, but it was ultimately her responsibility to ensure residents were being bathed. Record review of the facility's in-service dated 3/9/22 titled Resident Shower Days revealed . residents are to be showered on the assigned shower days, a shower list can be located at the nurses station . CNAs are to document skin issues on the skin sheet, sign and date, and give it to the charge nurse . if the resident refuses the charge nurse was to be notified . bed baths are only to be given at the charge nurse's approval . there are no exceptions . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Activities of Daily Living (ADLs), Supporting policy dated March of 2018 revealed . residents will be provided with care, treatment, services as appropriate to maintain or improve their ability to carry out activities of daily living . residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good nutrition, grooming, and personal and oral hygiene . appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care) . Record review of the facility's Shaving policy dated February 2018 revealed . the purpose of this procedure is to promote cleanliness and to provide skin care . the following information should be recorded in the resident's medical record; date & time of procedure performed, name & title of whom performed the procedure, any problems or complaints, if the resident participated in the procedure, if the resident refused the treatment, and signature of the person recording the data .

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 of 1 resident (Resident #34) reviewed for respiratory care related to tracheostomy care. The facility failed to ensure nursing staff had the needed competencies to care for a resident with a tracheostomy (Resident #34). The facility failed to ensure nursing staff were knowledgeable of how to administer inhalation medications for a resident with a tracheostomy (Resident #34). An Immediate Jeopardy (IJ) situation was identified on 08/19/2022 at 4:43 p.m. While the IJ was lifted on 08/22/2022 at 1:36 p.m. the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of patterned due to the facility's need to evaluate the effectiveness of their corrective systems. Findings included: Record review of a face sheet dated 8/1/22 revealed Resident #34 was a [AGE] year-old male that admitted to the facility on [DATE] with the diagnoses of multiple sclerosis (nerve damage that disrupts the communication between the brain and the body), acute and chronic respiratory failure (difficulty breathing and the lungs do not get enough oxygen), hypertension (high blood pressure), pneumonia (infection that inflames the air sacs in the lungs and may be filled with fluid or pus), malnutrition (the body does not get enough nutrients), Stage 4 pressure ulcer (wound caused by pressure that has loss of tissue and exposed muscle or bone), and a history of coronavirus 2019. Record review of an admission MDS dated [DATE] indicated Resident #34 was unable to perform the BIMS. Resident #34 was total dependent and required the assistance of two people for all ADLs. Resident #34 was always incontinent (unable to control) of bowel, and he had a foley catheter (tube into the bladder to drain urine). Resident #34 had a tracheostomy (direct airway into the trachea (windpipe) through a surgical incision in the neck). Resident #34 was unable to communicate with others. Record review of Resident #34's care plan dated 06/23/2022 revealed it did not address he had a tracheostomy or the care of the tracheostomy. Record review of the physician order report with a date range of 7/01/22-7/31/22 revealed Resident #34's was to receive ipratropium-albuterol sulfate (medication used to relax and open airway passages in the lungs to make breathing easier) 0.5mg/3mg every eight hours by nebulized inhalation and acetylcysteine (thins or dissolves mucus in the lungs) 400 mg by inhalation every eight hours. During an observation on 8/01/22 at 12:42 PM revealed LVN W removed a mask with a nebulizer (device to deliver inhalation medication) attached from over Resident #34's nose/mouth and the resident had a tracheostomy (artificial airway made through the lower neck). (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 8/01/22 at 4:29 PM with LVN W, she said she was giving Resident #34 a nebulizer treatment with ipratropium-albuterol and his acetylcysteine by inhalation. The resident had a mask over his nose and mouth with a nebulizer attached. Resident has a tracheostomy in his neck that he breathes through. During an observation on 8/01/22 at 5:22 PM revealed Resident #34's humidifier tubing was not attached to the resident's tracheostomy and was lying in the floor during a linen change followed by wound care being provided by LVN W and TCNA V. LVN W realized after four minutes, the tubing was not attached to Resident #34's tracheostomy, and she picked it up off the floor and reattached the humidifier tubing to the resident's tracheostomy without sanitizing it. During an interview on 8/01/22 at 6:05 PM with LVN W , she said she had been employed with this company for 2 months as the corporate mobile staffing nurse, but she had worked for the company since 2018 as an agency staffing nurse. She said she did not know any other way to give Resident #34's breathing treatment except over his nose/mouth, because he also had to have his oxygen on at all times, so his oxygen wouldn't drop. Surveyor asked LVN W how was Resident #34 inhaling the inhalation medication when the mask was over his nose/mouth, and he breathed through his tracheostomy located in his lower neck? LVN W said, you don't think he can get it through his nose? She then said, I get what you are saying, and he probably should have an attachment for the tracheostomy to give his breathing treatments. She said she had been checked off on tracheostomy care at another company owned facility and she had been providing care to residents with tracheostomies for a long time. She said she picked the tubing off the floor in a hurry be cause Resident #34 needed his oxygen quickly and she did not want his oxygen level to drop. The tubing she referred to was the humidified air tubing and did not contain oxygen. She said she checked his heart rate and oxygen level before and after giving Resident #34 his breathing treatments or suctioning him. She said she would report any changes to the physician and the DON and/or would call emergency services if needed. During an interview on 8/02/22 at 9:59 PM with LVN Y, she said she had been administering Resident #34's nebulized inhalation treatments with a mask over his nose/mouth, since the resident was admitted to the facility. She said she was just told that day the facility was ordering the attachment to be able to administer the inhalation medications through his tracheostomy. She said she would notify the physician with any changes in condition and/or would call 911 emergency services if needed. During an interview on 8/03/22 at 11:11 AM with LVN Z, she said she had been administering Resident #34's nebulized inhalation breathing treatments by putting the medication in the nebulizer and placing the face mask on his face. She said she checked his heart rate and oxygen levels before and after the breathing treatments. She said she made sure his head was elevated to ensure he was getting the medication. Surveyor asked LVN Z how she was ensuring the inhalation medication was reaching the resident's lungs through the face mask over his nose/mouth, when he breathed through his tracheostomy in his neck. She said she was told this week they had ordered an adapter so they could administer the inhalation medications through the tracheostomy mask. She said if Resident #34 was not getting the inhalation breathing treatment medications to his lungs, it could affect his breathing. She said she would notify the physician or nurse practitioner if the resident had a change in condition and/or would call emergency services if needed. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/4/2022 at 8:45 AM with LVN A , she said she had not had any trainings related to tracheostomies or tracheostomy care. She was unaware of how to do anything with a tracheostomy other than how to give breathing treatments. She said there was a box in there and she had no idea what the dials did or what it was for. She said she did not touch it. She said if anything ever happened to the resident's tracheostomy, it could be dangerous if there was not a RN in the building to ask what to do. She said she would call 911 for emergency services in the event of an emergency. During an interview on 8/04/22 at 10:56 AM LVN Z, she said a Respiratory Therapist had come and taught her how to take the tracheostomy inner cannula out and clean it and put back in, how to and how long to suction a resident with a tracheostomy about 2 years ago. She said she was only able to take the inner cannula of the tracheostomy out and clean it. She said if the tracheostomy was to come out, she could not put it back in. She said a Register Nurse was the only one that could put it back it. She said there was not always a Registered Nurse in the building. She said she would call 911 and make sure the resident was breathing good if the tracheostomy was to come out and there was not a Registered Nurse in the building. She said the Big box was the humidifier, and it was to keep his mucus thin in his lungs. She said she felt comfortable providing care for a trach resident and would feel comfortable caring for him in an emergency. During an interview on 8/04/22 at 7:00 PM with the DON , she said a resident with a tracheostomy would not receive the inhalation medication in the nebulizer treatment by inhalation when the mask was placed over the nose/mouth, because the resident breathed through the tracheostomy in his neck. She said the resident would not receive the benefits of the medication. She said she was working on ordering an adapter to be able to administer the nebulized inhalation medications through the tracheostomy. She said she was responsible for ensuring staff had the knowledge and skills to care for all residents in the facility, including the resident with the tracheostomy. She said she was working on getting a respiratory therapist to come and provide training to all nursing staff in caring for residents with tracheostomies. She said no staff had voiced to her not knowing how to care for the resident with a tracheostomy. She said she did not have the competencies of the nursing staff related to caring for a resident with a tracheostomy and care of the equipment. She said the nursing staff would not know how to put the resident's tracheostomy back in if it became dislodged. She said there was not a replacement tracheostomy tube at Resident #34's bedside, but she kept them in her office. She said the nursing staff would either need to call the registered nurse (RN), if the RN was in the building, or they would need to call 911 for emergency services in case of an emergency. She said it would be an infection control issue if the humidifier tubing was on the floor and then hooked back up to the resident without first disinfecting it. She said Resident #34 already had a respiratory infection. She said she was responsible to ensure the staff had the knowledge and skills to provide appropriate care to a resident with a tracheostomy. During an interview on 8/04/22 at 7:34 PM with the Administrator, she said she would expect the nursing staff to have the appropriate knowledge to care for all residents. Record review of LVN W's orientation checklist trainings dated 6/20/22 revealed there was no training related to tracheostomy care. Requested nursing competencies on all nursing staff that performed tracheostomy care for Resident #34 on 8/03/22 at 3:00 PM and twice on 8/04/22 at 2:30 PM and 7:00 PM from the Regional Nurse and was not provided with the requested documentation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The surveyor reentered the building on 8/19/2022 at 2:00 PM, during observation and interview with the DON it was revealed there were internal agency nurses working at the facility that had not been trained on tracheostomy care. The DON stated there was no spare cannula in Resident #34's room because the Respiratory therapist that came in on 8/9/2022 to do in-service training used the spare cannula to teach trach care. The DON retrieved a new cannula from her office to leave at bedside. The DON explained it was extremely important to have a spare cannula for Resident #34 because if it becomes clogged or dislodged it would leave Resident #34 with no air way causing respiratory failure and potentially death. The surveyor notified the DON on 8/19/2022 at 4:43 p.m., that they had a current Immediate Jeopardy related to respiratory/tracheostomy care. The IJ template was emailed to the DON on 8/19/2022 at 4:53 p.m. and a Plan of Removal was requested. The plan of removal was accepted on 8/19/2022 at 8:06 p.m. by the Program Manager and included: Plan of Removal: Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on 8/19/2022, for Respiratory and Tracheostomy Care. Action Item: The resident was assessed on 8/18/22 by LVN Z. No adverse outcomes noted. Person Responsible: DON Timeline for completion: 8/19/22 Action Item: Respiratory training, education and competencies including tracheostomy care, the administration of inhalation medication and oxygen services were completed with the nursing staff on 8/9/22 by the Lincare Respiratory therapist. LVN Q was reeducated on 8/18/22 by the RN ADON education included Respiratory training, education and competencies including tracheostomy care, the administration of inhalation medication and oxygen services. All nursing staff will be retrained on tracheostomy care, the administration of inhalation medication, oxygen services via tracheostomy and the location of the second cannula by 8/20/22. New nursing staff will complete education and competency prior to working with residents with tracheostomy. Person Responsible: Nursing and administration Timeline for completion: 8/20/22 Action Item: A second cannula was verified to be at bedside by on 8/19/22 by DON. Person Responsible: DON Timeline for completion: 8/19/22 Monitoring: (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The resident was assessed on 8/19/2022 for signs and symptoms of respiratory distress. - Respiratory training, education and competencies including tracheostomy care, the administration of inhalation medication and oxygen services were completed with the nursing staff on 8/9/22 by the Lincare Respiratory therapist. - LVN Q was reeducated on 8/18/22 by the RN ADON education included Respiratory training, education and competencies including tracheostomy care, the administration of inhalation medication and oxygen services. All nursing staff will be retrained on tracheostomy care, the administration of inhalation medication, oxygen services via tracheostomy and the location of the second cannula by 8/20/22. - New nursing staff will complete education and competency prior to working with residents with tracheostomy - A second cannula was verified to be at bedside by on 8/19/22 by DON. On 08/22/2022 at 1:36 p.m., the administrator was informed the IJ was removed; however, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of patterned due to the facility's need to continue to monitor the effectiveness of their plan of correction. Record review of the facility's policy titled Tracheostomy Care dated August 2019 revealed . a replacement tracheostomy tube must be available at the bedside at all times . There was a blank Competency Assessment Tracheostomy Care check off list attached to the policy.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 44933 Based on observation, interview, and record review, the facility failed to provide sufficient number of CNAs on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 8 of 21 residents reviewed for care and services. (Residents #1, #23, #32, #10, #49, #30, #57 and #56) The facility failed to provide sufficient staff on the 6 am-6 pm (07/01/2022-08/02/2022) and the 6 pm-6 am (07/01/2022-08/02/2022) shifts to meet the needs of the residents who required assistance with transfers, incontinent care, and activities of daily living. These failures lead to residents being transferred unsafely with one person for mechanical lifts, not receiving timely incontinent care leading to skin irritations, and not receiving baths leading to embarrassment and harm to health and safety of residents This failure could place residents who required assistance from staff for ADLs at risk for infection, skin breakdown, low self-esteem, and or depression. Findings included: Upon entrance into the facility on [DATE] at 9:00am the Administrator took the surveyors through the building to the back hall to an empty room. On the way there was a resident walking in the hall with t-shirt and soggy brief down to her knees, no pants with hair in disarray. The pungent odor made surveyors gag all the way down the hall and eyes water from the ammonia smell. Breakfast was still being served at this time. On the way down the hall the Administrator kicked a large (2-3 inch) water bug with her foot to the side. The survey team was placed in room with yellow stains on the wall with a strong urine odor. [NAME] stains were noted on the bathroom walls also. Record review of the Facility Assessment Tool updated on 7/26/2022, revealed the facility's average census for the past 12 months was 62 residents and the number of staff needed to work was 5 CNAs on day shift and 5 CNAs on evening/night shift, for a total of 10 CNAs in a 24 hour period. Updated on 7/26/2022 related to the addition of the specialized behavioral unit and 12-hour CNA shifts. Record review of the 2021 Facility Assessment Tool with the average census of 61 required 11 CNA's in a 24-hour period. Record review of the Daily Staffing Sheets dated 7/1/2022 to 8/2/2022 showed the following worked: average census 62 *07/01/2022 (6am-6pm) 2 CNAs and 2 CNAs (6pm-6am) *07/02/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *07/03/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	*07/04/2022 (6am-6pm) 2.5 CNAs and 3 CNAs (6pm-6am) *07/05/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/06/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/07/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/08/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/09/2022 (6am-6pm) 2 CNAs and 2 CNAs (6pm-6am) *07/10/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/11/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/12/2022 (6am-6pm) 2 CNAs and 4 CNAs (6pm-6am) *07/13/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/14/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *07/15/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/16/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/17/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/18/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/19/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/20/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/21/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/22/2022 (6am-6pm) 4 CNAs and 3 CNAs (6pm-6am) *07/23/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/24/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/25/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/26/2022 (6am-6pm) 4 CNAs and 3 CNAs (6pm-6am) *07/27/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	*07/28/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/29/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *07/30/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *07/31/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *08/01/2022 (6am-6pm) 3 CNAs and 1 CNAs (6pm-6am) *08/02/2022 (6am-6pm) 4 CNAs and 2 CNAs (6pm-6am) Record review of the CMS 672 dated 08/01/2022 indicated a census of 62 with the following: *20 residents required assist of one or two staff for bathing. *39 residents were dependent for bathing. *53 residents required assist of one or two staff for dressing. *9 residents were dependent for dressing. *51 residents required assist of one or two staff for transfers. *10 residents were dependent for transfers. *44 residents required assist of one or two staff for toilet use. *18 residents were dependent for toilet use. *58 residents required assist of one or two staff for eating: and *3 residents were dependent for eating. 1. Record review of the face sheet revealed Resident #1 was [AGE] year-old male that was admitted on [DATE] with diagnoses including CVA (stroke), bipolar disorder (disorder associated with episodes of mood swings) and hemiplegia (one-sided paralysis). Record review of the annual MDS dated [DATE] indicated Resident #1 had a BIMS of 15, which indicated no cognitive impairment. The MDS indicated he required limited assistance with ADLs, and he had physical behavioral symptoms directed towards others and verbal behavioral symptoms directed toward others exhibited 1 to 3 days. During an interview on 8/3/2022 at 8:12 am, Resident #1 stated he was upset and wanted to file a grievance because he did not get a supper tray the previous night and did not get any nighttime medication. Resident #1 stated he had his call light on for hours without it being answered and when they came in the aide said she was the only one here. Resident #1 stated there is never enough staff. It does not matter the day of the week of the time of day, it takes forever to get assistance. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	2. Record review of a face sheet revealed Resident #23 was a [AGE] year-old male, that admitted to the facility on [DATE] with the diagnoses of anemia (low iron in the blood), hypothyroidism (A condition in which the thyroid gland doesn't produce enough thyroid hormone), and edema (swelling). Record review of an MDS dated 6 /08/2022 indicated Resident #23 had a BIMS of 08, which indicated a mild cognitive deficit. Resident #23 required extensive to extensive assistance with ADLs of personal hygiene and bathing. Resident #32 was understood and understood others. Record review of a care plan dated 7/27/2022 titled ADL care listed an intervention to aid with bathing/showering 3 times per week and a sponge bed bath on non-shower days if needed. During an observation on 8/1/2022 at 9:33AM, Resident #23 stated he only got a bath about once every 2 weeks and had not had his hair washed in a couple months. Resident #23's hair was noted to be greasy. There was a strong smell of urine noted when entering the room. When asked if he would like a bath 3 days a week, he stated at least twice a week would be nice since he peed on himself so he could keep my skin clean. Resident #23 was noted to have long dirty fingernails. They were noted to be 3/4 inch from fingertips with a brown substance under all nails. There were yellow stains noted to his pillowcase when he lifted his head. Gray stubble covered Resident #23s face, approximately 1/2 inch long. Resident #23 stated the facility shaved him last week when he got his bath, but he liked to be shaved clean. Resident #23 stated he would like more than one bath a week but not every day. He stated he liked to feel clean it made him feel and smell better. Record review of the point of care ADL report dated 5/26/2022-6/30/2022, there was documentation of 5 baths being given (6/11,6/21, 6/23,6/25, and 6/30). According to the bath schedule Resident #23 should have received 15 baths in this time. No refusals were documented, or care planned for Resident #23. 3.Record review of a face sheet revealed Resident #32 was a [AGE] year-old-male that was admitted to the facility on [DATE] with the diagnosis of CVA (stroke), hemiplegia of dominant side (paralysis on right side of body), and protein calorie malnutrition. Record review of the MDS dated [DATE] revealed Resident #32 was usually understood and usually understood others. Resident #32 was noted to have a BIMS of 04 which indicated a significant cognitive impairment and he required extensive assistance with ADLs such as transfer, bathing, and bed mobility. Record review of a care plan for Resident #32 dated 6/29/2022 titled general had interventions listed for nail care to be done every Tuesday, Thursday, and Saturday on the 6pm to 6am shift. The interventions also listed bathing to occur every Tuesday, Thursday, and Saturday on the 6pm-6am shift. During an observation and interview on 8/1/2022 at 9:33AM, Resident #32 was noted to have a foul odor of ammonia and feces. The resident had dirty long fingernails with thick brown gummy like substance underneath that were 3/4 to 1 inch from the tip of fingers. When asked if he would like a bath, Resident #32 shook his head yes and stated yeah. Record review of the point of care ADL report dated 5/26/2022-6/30/2022, there was documentation of 6 baths being given of the 15 baths due during this time frame. No refusals were documented, or care planned for Resident #32. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	4. Record review of the face sheet dated 8/4/22 revealed Resident #10 was [AGE] years old, male, and admitted on [DATE] with diagnoses including muscle wasting and atrophy, and quadriplegia (paralysis of all four limbs). Record review of the MDS dated [DATE] revealed Resident #10 was understood and understood others. The MDS revealed Resident #10 had adequate vision. The MDS revealed Resident #10 had a BIMS of 14 which indicated intact cognition and required extensive assistance with two people assist for dressing, bed mobility, and transfers. And required total dependence with two people assist for toilet use, personal hygiene, and bathing. Record review of the care plan dated 7/13/22 revealed Resident #10 had self-care deficit related to quadriplegia as evidence by required assistance with ADLs. Intervention included total x 1-2 assistance with bath/showering 3 times a week. The care plan revealed Resident #10 had episodes of resisting care including showers. Interventions included monitor for early signs of behavior, approach in calm manner, and when refuses care re-approach later, notify nurse to document in chart. Record review of a care plan dated 7/13/22 revealed Resident #10 required total assist x2 (with lift) for transfers. Record review of the point of care history dated 5/4/22-8/4/22 revealed Resident #10 received no baths documented in May 2022. In June 2022, Resident #10 received 3 (6/23/22,6/25/22,6/27/22) partial bed baths (bathing the following areas: face, hands, underarms, back, buttocks and genital) and showers (6/24/22, 6/25/22, 6/30) out of 13 days. In July 2022, Resident #10 received 12 partial bed baths (7/1/22,7/3/22, 7/6/22, 7/7/22, 7/8/22, 7/11/22,7/12/22, 7/25/22, 7/26/22, 7/27/22, 7/29/22, 7/30/22) 2 showers (7/5/22,7/23/22), and 1 complete bed bath (7/26/22) out of 13 days. No refusals were documented on the point of care history. During an interview and observation on 8/1/22 at 10:30 a.m., Resident #10 said he had not had a shower since Wednesday (7/27/22). Resident #10 had greasy hair with dry, white patched noted to his scalp. Resident #10 said his hall only had one CNAs for a lot of residents. He said on the weekends, folks barely came to work. 5. Record review of the face sheet dated 8/4/22 revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis, need assistance with personal care, and muscle wasting and atrophy (shortening). Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance for bed mobility, transfers, and personal hygiene. And total dependence for dressing and bathing. The MDS dated [DATE] revealed Resident #49 was a tobacco user. Record review of the undated care plan revealed Resident #49 was a fall, safety, elopement risk with interventions of encourage use of call light and keep call light within reach. The undated care plan revealed Resident #49 would have the following tasks documented in POC. Intervention included bath/showers on Tuesday, Thursday, and Saturday on the 6am-6pm shift. Bathing/hygiene assist amount not specified. Record review of the undated care plan revealed Resident #49 was a smoker. Intervention included need to wear a smoking apron. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 8/1/22 at 10:30 a.m., Resident #49 was in bed with his call light on the floor. Resident #49 said he did not know where his call light was but even if he had it, staff do not answer it. He said if he needed assistance then he must holler out but he said his voice was not that loud so he could not be heard. During an interview on 8/2/22 at 10:00 p.m., Resident #49 said he was out of snuff and the person who used to buy it for him does not anymore. He said he would really like to smoke a cigarette, but no one will get him up. He said staff do not want to get him up to smoke because he needs to be put back to bed soon afterwards. He said he cannot sit up for long periods of time because of his back issues. He said he has been a smoker for half of his life, and it sucked he could not do it now. During an interview on 8/3/22 at 10:37 a.m., CNA N said Resident #49 was a smoker, but he wanted staff to immediately put him back to be afterwards. She said due to lack of staffing, she could not accommodate him. She said she normally worked the back hall which had 15 residents and most to all required some type of assistance with ADLs. She said the back hall had a lot of smokers so that took a lot of time and non-smoking resident's call lights were not being answered timely. She said since she was the CNA coordinator, if she could not find staffing after call ins, she had to come in to cover the shift. During an interview on 8/4/22 at 5:40 p.m., the DON said it was not right for Resident #49 to be denied smoke breaks because staff did not want to put him back to bed. She said it infringed on his right to smoke. She said Resident #49 being denied his smoke breaks could cause depression because he cannot do something he likes. She said he already had depression issues because of his loss of independence. During an interview on 8/4/22 at 6:30 p.m., the Administrator said not allowing Resident #49 to smoke due to lack of staffing was not an excuse. She said Resident #49 had the right to smoke and to be assisted out of bed to smoke. She said she did not know that Resident #49 wanted to smoke cigarettes and was being denied by staff. She said the resident rights were supposed to be reviewed in resident council meetings but a copy of it was in the admission packet. She said not all residents sign their admission packets and may not have received a copy of the resident rights. She said residents not knowing their residents' rights could make them feel unheard with no voice in their home leading to depression and anxiety. 6. Record review of the face sheet dated 8/1/22 revealed Resident #57 was [AGE] years old, male, and admitted on [DATE] with diagnoses including chronic pain syndrome, muscle wasting and atrophy, functional quadriplegia (a person affected by paralysis of all four limbs), and polymyositis (an uncommon inflammatory disease that causes muscle weakness affecting both sides of your body) with myopathy (a disorder of the skeletal muscles). Record review of the MDS dated [DATE] revealed Resident #57 was understood and understood others. The MDS revealed Resident #57 had a BIMS of 15 which indicated intact cognition and required total dependence for all ADLs. The MDS revealed Resident #57 rejected evaluation or care 1 to 3 days. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Record review of the undated care plan revealed Resident #57 the following tasks will be documented in POC. Interventions included bath/showers and nail care on Tuesday, Thursday, and Saturday on the 6pm-6am shift. The care plan revealed Resident #57 had limited physical mobility, bedfast all or most of the time related to diagnosis of functional quadriplegia. Intervention included reposition every 2 hours. Record review of the point of care history dated 5/4/22-8/4/22 revealed Resident #57 received 2 complete bed bath (5/28/22,5/29/22) and 1 partial bed bath (5/31/22) out 13 days in May 2022. In June 2022, Resident #57 received 5 complete bed baths (6/1/22, 6/2/22, 6/3/22, 6/7/22, 6/8/22), 3 partial bed baths (6/4/22, 6/5/22, 6/8/22), and 2 showers (6/3/22, 6/9/22) out of 13 days. In July 2022, Resident #57 had no documentation of bed bath or shower. No refusals were documented on the point of care history. Record review of the progress notes dated 7/11/22 -8/1/22 revealed no nursing documentation of bed bath/shower refusals. During an observation and interview on 8/1/22 at 11:27 a.m., Resident #57 was lying in bed with a large, yellow stained pillow. Resident #57 had greasy hair, flaky, dry skin to his face with redness noted, and long nails with brown matter underneath. Resident #57 said he had not had his hair washed since he was admitted . He said he sometimes gets bed bath, but they do not wash his hair. He said on 7/31/22, his urinal overflowed on to his sheets and no one came to change his linens for 12 hours. He said on the weekends and nights staffing was short, which is when he has the most issues. He said he had to call 911 to get help sometimes because they did not answer his call light or phone call to the front desk. Record review of meal report dated 7/3/22-8/3/22 revealed on 8/2/22 at 10:29 p.m. and 10:30 p.m., 51-75% supplements were taken by Resident #57 given by LVN I. The meal report revealed Resident #57 last documentation of intake on 8/2/22 was at 1:10 p.m. During an interview on 8/2/22 at 9:41 p.m., CNA H said she was doing the best she could as the only CNA for the back hall (15 residents) and the secured unit (21 residents). She said she did not have time to feed Resident #57. During an interview on 8/2/22 at 10:00 p.m., Resident #57 said he had not been fed supper yet. He said staff brought his dinner tray around 5:45 p.m., and he did not like the look of the pureed food, so he asked for a sandwich or bowl of fruit loops. He said staff took his tray and never came back. During an interview on 8/2/22 at 10:10 p.m., LVN I said she was unsure if Resident #57 was fed his supper, she said she had not fed him. She said she would not be surprised if he was not fed because night shift was short staffed. During an interview on 8/3/22 at 8:45 a.m., the Administrator said she sent the CNA, who came in to work to help night shift, feed Resident #57 a bowl of cereal around 10:45 p.m. 7. Record review of the face sheet dated 8/3/22 revealed Resident #30 was [AGE] years old, female, and admitted on [DATE] with diagnoses including spastic diplegic cerebral palsy (a form of cerebral palsy, a neurological condition that usually appears in infancy or early childhood, and permanently affects muscle control and coordination), lack of coordination, and muscle weakness. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Actual harm Residents Affected - Few	Record review of the MDS dated [DATE] revealed Resident #30 was understood and understood others. The MDS revealed Resident #30 had a BIMS of 15 which indicated intact cognition and required total dependence with 2 plus people assist with all ADLs. Record review of the care plan dated 4/27/22 revealed Resident #30 required total x 2 people with lift for transfers. During an interview on 8/2/22 at 4:23 p.m., Resident #30 said call lights were not regularly answered timely. She said the facility was short staffed especially on the weekends and if there was not enough staff, CNAs will not get you up. She said she was transferred with lift x 1 person 98% of the time. 8. Record review of the face sheet dated 8/4/22 revealed Resident #56 was [AGE] years old, female, and admitted on [DATE] with diagnoses including osteoarthritis, need for assistance with personal care, and muscle wasting and atrophy (shortening). Record review of the MDS dated [DATE] revealed Resident #56 was understood and understood others. The MDS revealed Resident #56 had a BIMS of 7 which indicated severe cognitive impairment and required total dependence with transfers. Record review of a care plan dated 7/27/22 revealed Resident #56 had self-care deficit related to dementia/bipolar disorder/muscle weakness as evidence by required assistance with ADLs. Intervention included total assist x 1-2 people for transfers. During an interview on 8/1/22 at 2:50 p.m., Resident #56 said she had not been changed since breakfast time around 7:00 a.m. She said it burned when she urinated and the odor when they change her was embarrassing. She said she got a bed bath about once a week. She said staff took about 1-2 hours to answer call lights and it happened about three times a week. During an interview on 8/2/22 at 9:41 p.m., CNA H said she was doing the best she could as the only CNA for the back hall and the secured unit. She said she had not given any bathes this evening. She said there was no way she could do that by herself. She said it was short staffed 90% of the time. CNA H stated she had no choice but to leave the secured unit unattended to help the nurse get people to bed. CNA H said occasionally there will be a day we have 4 CNA on night shift. During an interview on 8/2/22 at 10:30 p.m., the Administrator said the staffing numbers for the facility was to have 5 CNAs on day and night shifts, but she felt the facility ran well with 3 staff members. The Administrator was made aware of having only 2 CNA's this night shift, no showers had been given, and the secure unit was left unattended. During an interview on 8/3/22 at 10:03 a.m., TCNA L said she had been at the facility for a month. She said she normally worked the front and center halls. She said residents do not get their scheduled bed baths or showers due to lack of staff. She said if a resident was scheduled for a bed bath or shower on the night shift, it probably was not going to get done. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/3/22 at 10:37 a.m., CNA N said she was the CNA staff coordinator and worked the floor. She said call lights should be always in reach and functioning. She said due to lack of staffing, call lights were not answered timely, and residents did complain to her about call light response time. She said call lights not being in reach or non-functioning could cause falls and resident's needs not being met. She said due to lack of staff, residents did not get their scheduled bath/showers, nail care or oral care. She said she tells the CNAs to at least wash the residents face and hands. She said CNAs did not wash resident's hair if they got bed baths. During an interview on 8/4/22 at 5:40 p.m., the DON said call lights not being answered, in reach, or non-functioning could cause more falls. She said anyone that enters the room to provide care for the residents, was responsible for the call light being in reach. She said resident having to wait for long period of time to get changed could cause skin issues. She said it could make the resident feel sad because they may not feel important or seen. The DON said she knew ADLs were not getting done due to staffing issues. She said staff are burnout and don't want to come in on their off day. She said residents not getting showers/bed baths, hair washed, nail care, and overall personal hygiene could cause skin integrity issues and infections. She said resident can become depressed from not getting ADLs done. She said residents needs not being met can cause behaviors. The DON stated the administrator and corporate come up with the staffing numbers based on census and acuity and those are the numbers that the staffing coordinator are instructed to staff. However, it was a matter of not having enough people employed to fill those positions. She stated it had been discussed several times in the past to slow down on or stop taking admissions until the facility was staffed properly but corporate would not hear of it. During an interview on 8/4/22 at 6:30 p.m., the Administrator said residents having their call light in reach and functioning was very important for everyone. She said having non-functioning call light or call light not within reach could lead to falls, increased skin problems, and unhappy residents. She said all CNAs and nurses were responsible for ensuring call lights in reach and functioning properly. She said if staff found a call light out of reach, they need to put it within reach. The Administrator said being short of staff can affect resident care and make them miss baths, grooming, activities, have skin issues, miss medications, and have decreased quality of life. The Administrator stated she was responsible for making the facility assessment and she did include thing like acuity of residents and diagnosis to come up with the numbers for care givers. During record review an in service titled Secure Unit Staffing form 3/2/2022 stated: The secure unit will have a minimum of two nursing staff members on the unit at all times. If one member leaves the unit, the nurse must be notified so that a replacement can be placed. The secure unit nurse is accountable for having appropriate staff on the unit at all times. During an observation on 8/2/2022 at 9:50PM there were no employees on the secured unit with 18 residents present. The one CNA assigned to the unit was outside of the unit assisting the nurse to put other residents to bed. There were 2 CNAs and 2 nurses in the entire building with 63 residents at that time. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Record review of grievances and in services revealed grievances filed concerning call lights not being answered timely on 2/11/2022 (Resident #1), 3/18/2022(Resident #56), 4/14/2022 (family member), 4/14/2022 (ombudsman), and 8/3/2022 (Resident #1). An in service was done on 3/2/2022 by that revealed: call lights will be answered promptly and in a timely manner. Residents are to be addressed in a professional manner using their last name unless they are direct otherwise. If upon entering the resident's room, you are not able to address the resident's need you will leave the call light on and get the appropriate help. If you are able to meet the resident's need you will turn off the light and complete the desired task. Call lights must always be within reach and in working order. During an interview on 8/3/2022 at 10:03 am TCNA L stated residents do not get scheduled baths or call lights answered timely. TCNA L stated it was hard to get help because the facility was always short staffed. TCNA L said she was seriously considering quitting because how stressful the job was. TCNA L stated some of the resident's behaviors are due to not having enough staff and waiting such a long time for help. During an interview on 8/3/2022 at 10:37 pm CNA N stated there was supposed to be 10 CNAs staffed in the building every 24 hours due to the number and type of residents they cared for. CNA N stated they staffed 4 CNAs on day shift which included her and 3 on night shift on average. CNA N stated everyone was aware of shortage and it was because they paid $9.00 or $10.00 an hour and the gas station across the street paid $13.00 an hour. CNA N stated the population in the building was difficult to work with and people were not going to do it for nothing. CNA N stated she was aware that call lights were not answered timely, of the lack of showers and bed baths given, and that the residents did not get their hair washed when getting a bed bath. CNA N stated she knew mechanical lifts should always be done with 2 people, but she did them on her own because there was not enough staff and she considered herself a seasoned CNA. A policy was requested on 8/3/2022 at 3:45pm for sufficient staffing from the administrator. The policy was requested again on 8/4/2022 at 1:10pm from the RN consultant. No policy was given regarding sufficient staffing.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #57) of 21 residents reviewed for pharmacy services. The facility failed to ensure accurate medication administration and documentation for Resident #57. This failure could place the residents at risk of not having accurate records of medication administration. Findings included: Record review of the face sheet dated 8/1/22 revealed Resident #57 was [AGE] years old, male, and admitted on [DATE] with diagnoses including chronic pain syndrome, muscle wasting and atrophy, functional quadriplegia (a person affected by paralysis of all four limbs), and polymyositis (an uncommon inflammatory disease that causes muscle weakness affecting both sides of your body) with myopathy (a disorder of the skeletal muscles). Record review of the consolidated physician orders dated 7/1/22-8/1/22 revealed Resident #57 had order for Colace (stool softener) dated 3/23/22, 100 mg, 1 capsule oral twice a day (7am-10am & 7pm-10pm). The consolidated physician orders revealed Resident #57 had order for hydrocodone-acetaminophen (Norco-relieve moderate to severe pain) dated 3/2/22, 10-325 mg, 1 tablet oral every 6 hours at 1200am, 6:00 a.m., 12:00 p.m., 6:00 p.m. The consolidated physician orders revealed Resident #57 had order for Remeron dated 7/26/22, 15 mg, 1 tablet oral at bedtime (7:00 p.m.-10:00 p.m.). The consolidated physician orders revealed Resident #57 had order for trazodone dated 3/9/22, 50 mg 1 tablet oral at bedtime (7:00 p.m. -10:00 p.m.). The consolidated physician orders revealed Resident #57 had Vitamin C dated 3/9/22, 500 mg, 1 tablet oral at bedtime (7:00 p.m.-10:00 p.m.). Record review of the MDS dated [DATE] revealed Resident #57 was understood and understood others. The MDS revealed Resident #57 had a BIMS of 15 which indicated intact cognition and required total dependence for ADLs. Record review of the undated care plan revealed Resident #57 had limited physical mobility, bedfast all or most of the time related to diagnosis of functional quadriplegia. Record review of the Medication administration record dated 8/1/22-8/3/22 revealed on 8/2/22 between 7:00 p.m. -10:00 p.m., CMA EE charted she administered Colace, Remeron, Trazodone, Norco, and Vitamin C. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/2/22 at 10:00 p.m., on Resident #57's bedside table was a small clear cup with yellow pudding consistency and mini tongue depressor. This surveyor asked Resident #57 what was in the cup, and he said my nighttime medication. He said CMA EE came to give him his scheduled medication but because he had snuff in his mouth, she refused to give it to me. He said CMA EE refused to take his snuff out of his mouth, but he cannot physical do it. He said CMA EE left the cup on his bedside tray and told CNA FF to take his snuff out when he got a minute and give him his medication. Resident #57 said his Norco and Colace was in the medicine cup. LVN I was called to the bedside to verify what was in the cup. LVN I said she did not know what was in the cup and morning staff did not tell her Resident #57 medication were not given. LVN I said CNA FF did stay after his schedule shift to help night shift for a little while. LVN I said he was in Resident #57's room when CMA EE was passing out meds. LVN I said CNAs were not allowed to give medications to residents. She told Resident #57 since she did not know which medications were in the cup, she could not administer it. Resident #57 said he was in pain and wanted his pain medication, Norco, and Colace. LVN I said she would have to notify the physician to give another dose because his next dose of Norco was due at 1200 a.m. She said she would notify the DON of this incident. During an interview on 8/2/22 at 10:30 p.m., the Administrator was made aware of the medication incident with Resident #57. She said it was unacceptable to leave any medications at a resident's bedside. She said it was unacceptable because another resident could come along, take it, and cause harm. During an interview on 8/3/22 at 9:19 a.m., MA EE said she did pass out Resident #57's pm medications. She said she prepared Resident #57's Norco around 6 p.m. and placed it in his protein liquid. She said he preferred his medications that way. She said her and Resident #57 did not get along. She said she gave LVN C Resident #57's Norco because he was heading into the room. She said she came back later and gave Resident #57 the rest of his medications. She said she thought it was Remeron, Colace, and Vitamin C. She said she did mix them in pudding and left it at the bedside to be given by CNA FF. She said she did not give him his medication because he had snuff in his mouth, and she refused to take it out. She said snuff was disgusting and the facility did not require her to remove resident's snuff from their mouth. She said on occasions, she let CNAs give medications, but she always watched them. She said she did not know if that was wrong or not. She said it was hard to pass out all resident's medication on time and she could only do so much. She said the night nurses were supposed to give 7pm-10pm medications, but they refuse to do it. During an interview on 8/3/22 at 9:40 a.m., LVN C said he did give Resident #57 his Norco for CMA EE. He said he saw CMA EE crush and mix it in his protein liquid supplement. He said since he watched her throughout the whole process, he thought it was okay for him to give it. During an interview on 8/4/22 at 5:40 p.m., the DON said the facility only had one med aide. She said they recently switched to liberalized med times hoping it would help with late administration. She said the old way of 1 hour before and 1 hour after grace period, caused late administration too. She said the facility's resident did not need their meds late because of the type of meds they took. She said medications still had to be safely administered and accurately documented. She said only nursing staff and CMA could administer medications. During an interview on 8/4/22 at 6:30 p.m., the Administrator said medication errors can cause a lot of different effects on residents. She said if a resident was given something not ordered, it could cause organ damage and even death. She said not getting medications can cause the resident to have seizures, blood clots, high blood sugar, and even death if it was not corrected. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/22 at 7:23 p.m., attempted to contact CNA FF x2, call forwarded then unable to leave message due to voicemail not being set up. Record review of a facility Administering Medication policy dated April 2019 revealed .medications are administered in a safe and timely manner, and as prescribed .only person licensed or permitted by this state to prepare, administer, and document the administration of medications may do so .the individual administering the medication document in the resident's electronic record after administering each medication .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46299 Based on observation, interview and record review, the facility failed to ensure the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist for 1 of 18 residents reviewed for drug regimen review (Resident #59). The facility failed to ensure Resident #59s physician and medications orders were available to the licensed pharmacist on admission for review. This failure could place residents at risk of having adverse consequences related to medications not being properly reviewed. Findings included: Record review of the 07/04/22 Admission Face Sheet with Diagnoses for Resident #59, a [AGE] year-old male, revealed psychosis, Hyperlipidemia (high cholesterol), Post Traumatic Stress Disorder (trauma induced), Depression, Anxiety, Dementia (the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities), Hypertension (high blood pressure), Cerebral Infarction (stroke) and lack of coordination with muscle weakness. Record review of the 07/11/22 Admission MDS documented a brief interview for mental status noting long/short-term memory problems with severely impaired cognitive skills for daily decision making and continuous inattention. Resident #59 had a Total Severity Score of 04, indicating minimal depression. He exhibited physical behaviors directed at others and rejection of cares noted 1 to 3 days. He had 7 days of routine antipsychotics and antidepressants administered and 4 days of antianxiety medications administered. Record review of the 07/22/22 Comprehensive Care Plan revealed the resident was on hospice, medications to be given and vital signs completed as ordered. Pain management with medication, monitoring for signs and symptoms of bleeding, psychotropic drug use with behavior monitoring noted as well. Record review of the 07/04/22 to 08/02/22 Active Physician Orders revealed the resident received Amlodipine (blood pressure medication), Ativan with medication side effect monitoring (anti-anxiety medication), Atorvastatin (cholesterol medication), Depakote (mood medication), Folic Acid (vitamin B), Melatonin (sleep aide), Seroquel with antipsychotic medication monitoring (antipsychotic medication), Sertraline with antidepressant medication side effect monitoring (antidepressant), Thiamine (B1 vitamin), Trazadone with antidepressant medication side effect monitoring (antidepressant), Aspirin (antiplatelet medication) and was on Hospice. Record review of the 07/24/22 Pharmacy MRR revealed the licensed pharmacist recommended that the facility should please scan patient's admission orders to computer for review. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the 08/01/22 at 03:55 PM observation of Resident #59 revealed he would not make eye contact with this surveyor, but pleasant demeanor, dressed/groomed appropriately. No signs or symptoms of distress/pain and did not note any abnormal movements/affect. During the 08/03/22 at 10:41 AM interview the LVN P revealed she thought because Resident #59 came from a sister facility, that all his medication orders had already been scanned, or she would have done it herself. During the 08/03/22 at 10:43 AM interview the ADON stated I have not been trained on MRRs and have not been able to complete them in the month I have been in my position as ADON. The DON had been completing the MRRs I thought. This all affects the resident in that their medication orders may not be appropriate per regulations. During the 08/03/22 at 10:45 AM interview with the DON stated the admitting nurse puts in the physician orders in the resident's charts and the ADON is supposed to ensure the MRRs are completed monthly by the pharmacist. The old ADON quit a month ago, and I have been training the new ADON for her position, but it has been a lot. The resident gets their medications, so there is no negative impact. Attempted interviews on 08/11/22 at 08:46 AM, 11:07 AM and 01:38 PM with Licensed Pharmacist by phone revealed no answer, voicemail x3. Record review of the 05/2019 facility Medication Regimen Review Policy revealed the medication regimen reviews are done upon admission (or as close to admission as possible). The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication.

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure a resident did not receive medications without an indication for use for 1 (Resident #8) of 1 resident reviewed for unnecessary medications. The facility administered Resident #8 Haldol (antipsychotic used to treat schizophrenia) without trying other medication interventions, after behaviors exhibited from COVID-19 isolation. This failure could place residents at risk for receiving unnecessary medications. Findings included: Record review of the face sheet dated 8/1/22 revealed Resident #8 was [AGE] years old, female, and was admitted from the psychiatric hospital on 9/27/21 and 7/11/22 with diagnoses including major depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily), and generalized anxiety. Record review of the MDS dated [DATE] revealed Resident #8 was currently considered by the state level II PASRR process to have serious mental illness. The MDS revealed Resident #8 was understood and understood others. The MDS revealed Resident #8 had a BIMS of 14 which indicated intact cognition and required supervision-total dependence for ADLs. The MDS revealed Resident #8 did not exhibit physical, verbal, other behavioral symptoms. The MDS revealed Resident #8 liked to do things with groups of people, doing favorite activities, and go outside to get fresh air when weather is good was very important. The MDS revealed Resident #8 used a wheelchair for mobility. Record review of the care plan dated 6/22/22 revealed Resident #8 had impaired decision making related to diagnosis of Parkinson's with dementia. Interventions included clarify misconceptions, encourage self-evaluate, respect rights to make decisions, support, and reassure in new situations. The care plan indicated Resident #8 had emotional distress related to missing limbs. The care plan revealed psychotropic drug use with interventions of monitor side effects and target behaviors. Record review of the consolidated physician orders dated 8/2/22 revealed Resident #8 medications were the following: -Depakote Sprinkles (a mood stabilizer medication that works in the brain) 125 mg 2 capsules once a day in the morning (7am-10am) start date 7/11/22, -Depakote Sprinkles 125 mg 4 capsules at bedtime (7pm-10pm) start date of 7/11/22, - Gabapentin (works in the brain to prevent seizures and relieve pain for certain conditions in the nervous system) 100mg 2 capsules three times a day (morning, mid-day, and bedtime) started 9/27/21, -Klonopin (used to treat seizures and panic disorder) 1mg 1 tablet twice a day (morning and bedtime) started 8/1/22, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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F 0757 Level of Harm - Actual harm Residents Affected - Few	-Melatonin (helps with the timing of your circadian rhythms (24-hour internal clock) and with sleep) 3mg 3 tablets at bedtime started 7/12/22, and -Lexapro (an antidepressant medication that works in the brain. It is approved for the treatment of major depressive disorder (MDD)) 20 mg 1 tablet at bedtime started 8/1/22. Record review of the medication administration record dated 7/1/22-7/31/22 revealed Resident #8 was administered her morning medications of Depakote 125 mg (2 tabs), Gabapentin 100 mg (2 tabs), and Clonazepam 1mg. The MAR revealed Haloperidol 5mg tablet as needed q6h dated 7/13/22-7/18/22 with no administrations documented but a progress note completed by the DON revealed it was given on 7/13/22 at 12:16 p.m. Record review of the progress notes dated 7/11/22 at 8:00 p.m., written by RN DD revealed Resident #8 arrived at the facility from a psychiatric hospital with COVID-19. The progress note revealed clonazepam was increased to 1 mg at bedtime for anxiety and Lexapro decreased to 10 mg once a day. The progress note revealed new orders for melatonin 9mg at bedtime and Depakote sprinkle 250mg in the morning and 500 mg at bedtime. The progress note revealed discontinue Aricept (is used to treat confusion (dementia) related to Alzheimer's disease), bio freeze, Celebrex (is used to treat pain and redness, swelling, and heat (inflammation) from osteoarthritis), and tramadol (is a strong pain medication used to treat moderate to severe pain that is not being relieved by other types of pain medicines). Record review of the progress note dated 7/13/22 at 9:13 a.m., written by the DON revealed Resident #8 was in the hallway refusing to abide by quarantine rules due to her being covid positive. Resident redirected multiples times by this nurse and administrator. Resident verbally aggressive to staff but returned to room. Encouraged to use call light for needs and stay in her room and follow quarantine guidelines. Record review of the progress note dated 7/13/22 at 12:16 p.m., written by the DON, revealed Resident #8 in hall yelling and cussing at staff and trying to hit CNA in room. Attempted to throw self on the floor. Unable to redirect at this time NP K in facility and received an order for Haldol 5mg/1ml give 1ml intramuscular (IM) now and q6 hours prn for 5 days for aggressive behavior attempt to call Responsible Party, no answer at time. Haldol given to Left deltoid at time. Encouraged resident to calm down. And that she had to quarantine per CDC guidelines and that she could go back to her old room after 14 days. She agreed and apologized stated that she was claustrophobic. Explained that she could sit in doorway just could not go down the hall Record review of the progress note written by LVN GG dated 7/13/22 at 1:40 p.m., revealed due to Resident #8 being noncompliant with isolation and having multiple behaviors NP K was contacted. NP K gave orders for Haldol 5mg q6h prn x 5 days then review with NP K to extend orders or dc all together. Record review of the Resident #8's progress notes dated 7/16/22, 7/18/22, and 7/19/22 had no behaviors documented. Record review of Resident #8 clinical record revealed there was no documentation of a verbal or written consent for Haldol. (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Record review of the Behavior Monitoring dated 5/4/22-8/4/22 revealed Resident #8 had no behaviors documented on 7/13/22. Record review of the aggressive/combative behavior report dated 1/1/22-8/2/22 revealed no events involving Resident #8. During an interview and observation on 8/1/22 at 3:30 p.m., Resident #8 was sitting in her wheelchair in the common area. When this surveyor approached Resident #8 to interview her, she appeared nervous, she said Do you have shot? I have been good. During an interview on 8/4/22 at 9:00 a.m., NP K said she was informed by the DON, Resident #8 was slapping at staff and residents, see things, and trying to hurt herself. She said the DON told her they had attempted to redirect and remove Resident #8, but she was uncooperative. NP K said for safety I ordered Haldol. NP K said staff did not inform her if Resident #8 had received her morning medications or not. She said she did not order Ativan because it had not worked in the past. She said when resident displayed aggressive behaviors or agitation, we first try redirection then benzodiazepines (work to calm or sedate a person, by raising the level of the inhibitory neurotransmitter GABA in the brain. Common benzodiazepines include diazepam (Valium), alprazolam (Xanax), and clonazepam (Klonopin), among others) or a psychiatric hospital. She said Resident #8 had just left a psychiatric hospital two days ago, so we did not want to send her back. She said Resident #8 was putting others in jeopardy because she had COVID. She said Resident #8 was on the hall with one other COVID resident. She said the COVID positive hall was about 10-12 rooms down from non-COVID residents. She said we gave Resident #8 Haldol to keep her in the room for the safety of residents and staff. She said Resident #8's agitation may have been caused by being isolated. On 8/4/22 at 10:52 a.m., attempted to call Resident #8's responsible party, no answer, left message. On 8/4/22 at 10:54 a.m., attempted to call Resident #8's responsible party's relative, no answer, left message. During an interview on 8/4/22 at 3:46 p.m., LVN GG said she said she was not on duty when Resident #8 received the Haldol IM. She said she had to leave for a family emergency and the DON took over her hall. She said when she returned later, they told her what happened. They told her Resident #8 was upset because she did not want to stay in her room and acted out. She said she never had to use Haldol on her or other residents. She said Resident #8 was a social butterfly, so she probably did not like being isolated. She said there was one other resident on the hall who was a new admission. She said the non-isolated residents were 8-10 rooms down from the hot (COVID positive) hall. She said the facility normally tried snacks and activities before medications. She said snacks normally worked for residents. She said she thought Resident #8 had taken her morning medications. She said it was sad Resident #8 assumed new people were going to give her a shot and told them she had been good. (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/4/22 at 5:40 p.m., the DON said she worked the hall the day Resident #8 received the Haldol injection. She said Resident #8 was yelling and being aggressive to staff members. She said Resident #8 was on isolation due to being COVID positive. She said Resident #8 kept coming out of her room and going out the back door. She said they offered Resident #8 to sit in the doorway, snacks, tv, activities, and music but it would only help for a while. She said Resident #8 had calmed down then we gave her the Haldol shot. She said Resident #8 was fine afterwards. She said she did not know if Resident #8 had refused her morning medication and they did not try other medications for agitation. She said she did not see giving Resident #8 Haldol IM as unnecessary medication. During an interview on 8/4/22 at 6:30 p.m., the Administrator said the facility did not use chemical restraints on residents. The Administrator said she did not feel Resident #8 was chemically restrained. The Administrator said the medication was given to keep Resident #8 from spreading COVID to the rest of the building. She said nursing staff had a doctor's order for the medication, Haldol. The Administrator said she was not aware of other medications Resident #8 was taking or if they had tried other interventions prior to injecting Resident #8 with Haldol. Record review of a facility Behavioral assessment, intervention, and monitoring policy dated July 2019 revealed behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment .residents will have minimal complications associated with the management of altered or impaired behavior .the facility will comply with regulatory requirements related to the use of medications to manage behavioral changes . Behavior is the response of an individual to a wide variety of factors. These factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes . Behavior is regulated by the brain and is influenced by past experiences, personality traits, environment, and interactions with other people. Behavior can be a way for an individual in distress to communicate unmet needs, indicate discomfort, or express thoughts that cannot be articulated . Appropriate assessment and treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating underlying factors, and those that cannot . The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including . Onset, duration, intensity, and frequency of behavioral symptoms . b. Any precipitating or relevant factors, or environmental triggers (e.g., medication changes, infection, recent transfer from hospital); and .c. Appearance and alertness of the resident and related observations .New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others . The resident and/or resident surrogate will have the right to refuse treatment .Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms .When medications are prescribed for behavioral symptoms, documentation will include .Rationale for use .Potential underlying causes of the behavior .Other approaches and interventions tried prior to the use of antipsychotic medications .Potential risks and benefits of medications as discussed with the resident and/or family .Specific target behaviors and expected outcomes .Dosage . Duration .Monitoring for efficacy and adverse consequences .The Director of Nursing, or designee, will evaluate whether the staffing needs have changed based on acuity of the residents and their plans of care .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 44933 46299 Based on interviews and record reviews, the facility failed to ensure a gradual dose reduction was attempted for 3 residents (#4 and #10, #59) and failed to administer antipsychotic medication as ordered for 1 resident (#50) of 5 residents reviewed for unnecessary medications in that: 1. The facility failed to do a gradual dose reduction or document contraindication for a gradual dose reduction for Resident #4's ordered Seroquel 50mg daily and Seroquel 100mg at bedtime on 10/19/2021. 2. The facility failed to do a gradual dose reduction for Resident #10's Zyprexa (is a medication that works in the brain to treat schizophrenia) started on 2/1/21 3. The facility failed to administer the reduced order of Seroquel 200mg twice daily ordered on 7/4/2022. 4. The facility failed to ensure that resident PRN psychotropic, including antipsychotic, medication orders were limited to 14 days, not given unless for the appropriate specific/diagnosed condition documented in the clinical record and failed to ensure proper monitoring for Resident #59. These failures could place residents at risk for possible psychotropic medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. Findings included: 1. Review of the resident face sheet revealed, Resident #4 was a [AGE] year-old female that admitted on [DATE]. The face sheet revealed Resident # 4 had diagnoses that included, vascular dementia (brain damage caused by multiple strokes), mood disorder (a psychological disorder characterized by the elevation or lowering of a person's mood, such as depression or bipolar disorder), and schizophrenia(A disorder that affects a person's ability to think, feel, and behave clearly). Review of the MDS dated [DATE] indicated Resident #4 had a BIMS (brief interview of mental status) of 00, which indicated a severe cognitive impairment. The MDS revealed Resident #4 is rarely to never understood. The MDS revealed Resident #4 required extensive assistance with ADLs. No hallucinations, delusions, behavior, rejection of care or wandering was noted on the MDS. Review of physician orders dated 7/1/2022-7/31/2022 for Resident #4 revealed an order for Seroquel 50mg by mouth once daily and Seroquel 100mg by mouth once at bedtime from 10/19/2021. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of MAR (medication reconciliation record) for July of 2022 revealed administration of Seroquel 50mg daily each day except 7/1/2022, 7/2/2022, and 7/6/2022. The MAR revealed the administration of Seroquel 100mg at bedtime nightly from 7/1/2022-7/31/2022. No record of a gradual dose reduction was noted during review for months of November 2021 through July 2022. During an interview on 8/3/2022 at 4:15PM the DON stated she was unable to find any GDR attempts for Resident #4 at this time. During an interview on 8/4/2022 at 10:00 am pharmacy consultant stated no GDR was done on Resident #4 because she had a diagnosis of schizophrenia and was not made aware of the need for a reduction when serious a psychiatric diagnosis was attached to the medications. Serious side effects of the overuse of antipsychotic medications include dry mouth, dizziness, orthostatic hypotension, constipation, and the feeling of sedation which can increase the chances of the resident falling. 2. Record review of the face sheet dated 8/1/22 revealed Resident #10 was [AGE] years old, male, and admitted on [DATE] with diagnoses including schizoaffective disorder (disorder is a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), bipolar type, anxiety disorder, and severe bipolar with psychotic features (a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks). Record review of the consolidated physician orders revealed Resident #10 received Zyprexa 5mg 1 tablet oral at bedtime with a start date of 2/1/21. Record review of the MDS dated [DATE] revealed Resident #10 was understood and understood others. The MDS revealed Resident #10 had a BIMS of 14 which indicated intact cognition and required extensive assistance for ADLs. The MDS revealed Resident #10 did not have hallucination or delusions in the 7-day evaluation period but exhibited verbal behavioral symptoms directed towards others which significantly disrupt care or living environment. The MDS revealed Resident #10 had an antipsychotic medication. The MDS revealed Resident #10 received antipsychotic medication on routine basis only, gradual dose reduction had not been attempted, and had not been documented by physician as clinically contraindicated. Record review of the care plan dated 7/13/22 revealed Resident #10 had self-care deficit related to quadriplegia (paralysis of all four limbs) as evidence by required assistance with ADLs. The care plan revealed Resident #10 had memory and recall problems related to short term memory deficit. The care plan revealed Resident #10 was at risk for side effects of anti-psychotic drug use due to schizoaffective disorder, bipolar type. The care plan revealed Resident #10 had depression and anxiety related to loss of roles/status. 2. Record review of the Admission Face Sheet dated 07/04/22, with Diagnoses for Resident #59, a [AGE] year-old male with date of birth of 10/27/50, revealed diagnoses included psychosis not due to a substance or known physiological condition (severe mental disorder in which thought/emotions are so impaired that contact is lost with external reality) and Anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the 07/11/22 Admission MDS documented a brief interview for mental status noting long/short-term memory problems with severely impaired cognitive skills for daily decision making and continuous inattention. He had 7 days of routine antipsychotics and 4 days of antianxiety medications administered. Record review of the 07/22/22 Comprehensive Care Plan revealed the resident received psychotropic medications. Record review of the 07/04/22 to 08/02/22 Active Physician Orders revealed the resident received Ativan (anti-anxiety medication) as needed with no end date since 07/23/22 noted for the medication and Seroquel (antipsychotic medication) for generalized anxiety disorder since 07/04/22. Record review of the 07/04/22 to 08/03/22 resident chart for an Abnormal Involuntary Movement Scale (AIMS, rating scale to measure involuntary movements known as tardive dyskinesia) for antipsychotic medication side effect monitoring revealed that no assessment had been completed. During the 08/01/22 at 03:55 PM observation of Resident #59 revealed he would not make eye contact with this surveyor, but he displayed a pleasant demeanor with no signs/symptoms of distress or abnormal movements/affect at this time. During the 08/03/22 at 10:41 AM interview LVN P stated I check the diagnosis of the medications and ensure the diagnosis matches the paperwork. I did not complete an AIMS assessment for him because I thought one had already been done. During the 08/03/22 at 10:43 AM interview with the ADON stated I verify a residents Antipsychotic medication diagnosis for appropriateness and AIMS should be completed on admission by the nurse and quarterly with the MDS, I think. This all affects the resident in that their medication orders may not be appropriate per regulations. During the 08/03/22 at 10:45 AM interview with the DON stated any nurse can clarify a diagnosis on a medication, but we put the diagnosis that came from the physician paperwork. There should be an end date on a PRN psychotropic and antipsychotic medication, but no end date was provided on the medication orders from the physician. The residents got their medications, so there is no negative impact, other than it does not follow regulations. Attempted interviews on 08/11/22 at 08:46 AM, 11:07 AM and 01:38 PM with Licensed Pharmacist by phone revealed no answer, voicemail x3. Requested the facility policy for resident use of psychotropic medications from the Administrator and DON on 08/04/22, did not receive a policy as requested prior to survey exit. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the resident face sheet revealed, Resident #50 was a [AGE] year-old male that admitted to the facility on [DATE]. The face sheet revealed Resident #50 had diagnoses that included, cerebral palsy(A congenital disorder of movement, muscle tone, or posture), mild intellectual disability(deficits in intellectual functions pertaining to abstract/theoretical thinking), auditory hallucinations(when you hear voices or noises that don't exist in reality), schizophrenia(A disorder that affects a person's ability to think, feel, and behave clearly.), and legal blindness(occurs when a person has central visual acuity (vision that allows a person to see straight ahead of them) of 20/200 or less in his or her better eye with correction). Review of the MDS dated [DATE] revealed, Resident # 50 had a BIMS (brief interview of mental status) of a 14, which indicated no memory impairment. The MDS also indicated Resident #50 had 1-3 days of physical and verbal behaviors during the assessment period. Resident # 50 required extensive assist for bed mobility, transfer, and toileting. Review of physician orders for June 2022 and July 2022 indicated the following: June 2022: -Seroquel 300mg twice daily-Start date 11/27/2019 -Seroquel 400mg at bedtime-Start date 3/14/2021 July 2022: -Ativan 0.5mg twice daily- Start date 7/5/2022; Stop date 7/14/2022 -Ativan 0.5mg once daily- Start date 7/15/2022 -Lexapro 20mg once daily- Start date 7/5/2022; Stop date 7/14/2022 -Seroquel 300mg twice daily- Start date 11/27/2019; Stop date 7/5/2022 -Seroquel 400mg at bedtime-Start date 3/14/2021; Stop date 7/4/2022 -Seroquel 400mg twice daily- Start date 7/4/2022 Review of the progress note written by LVN A dated 7/3/2022 11:26 am revealed: resident destructive, throwing things around the room, pulling on blinds, and pushing over tables, resident verbally and physically aggressive toward staff, redirected and assisted up to wheelchair, resident continued to yell and curse at staff and attempted to pull down blinds. Review of the progress note written by Psychologist B dated 7/4/2022 at 12:54PM revealed: 'Resident #50 was seen for a follow up. Records and reports from other residents and staff indicated that Resident #50 had been aggressive and destructive lately .he suffers from serious schizoaffective disorder and low intellect, and lately it appeared that he underwent some psychiatric decompensation. He was provided counseling to help him stop any form of aggression, follow staff's recommendations, and engage with others in a clam and pleasant manner.' (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes written by LVN C on 7/4/2022 at 1:25pm revealed: New orders per NP K per psych PHD B recommendations to decrease Seroquel to 200mg orally twice daily, add Ativan 0.5mg orally twice daily, add Lexapro 20mg orally once a day. Review of progress notes written by LVN C on 7/8/2022 at 11:28 AM revealed: Day 5 new order per NP K per PHD B recommendations decrease Seroquel to 200mg orally twice daily, add Ativan 0.5mg orally twice daily, and add Lexapro 20 mg once a day. Resident has been noted sleeping a lot since med changes, slept through breakfast and ate only small bites of lunch due to sleeping in a wheelchair, to continue to monitor for tolerance of med changes. Review of progress note written by LVN C on 7/9/2022 at 10:49 am revealed: Day 6 new orders per NP K per psych PHD B recommendations decrease Seroquel to 200mg po (orally) qd (every day), add Ativan 0. 5mg po bid (orally twice daily), and Lexapro 20mg po qd (orally daily), resident continues to sleep a lot during the day hard to arouse at times. Review of a progress note written by LVN F on 7/12/2022 at 11:24 PM revealed: Day 9/14 new orders to decrease Seroquel to 400mg po bid (orally twice a day), add Ativan 0.5 mg po bid (orally twice daily), and Lexapro 20 mg po qd (orally once a day). Review of a progress note written by LVN C on 7/13/2022 at 12:07 PM revealed: Day 10 new orders per NP K per Psych PHD B recommendations decrease Seroquel to 200mg po bid (orally twice daily), add Ativan 0. 5mg po bid (orally twice daily) and Lexapro 20 mg po qd (orally daily). Stilly drowsy daily, ate 75% of breakfast with assistance due to drowsiness, normally could feed himself before medication changes, NP in the facility at this time to see the resident. Review of a progress note written by LVN C on 7/14/2022 at 6:54am revealed new order to decrease Ativan to 0.5mg twice daily to once daily. Resident requiring extra assistance with ADLs related to increased sedation, sleeping a lot during the day. At 1:58PM Resident ate 75% of his meal with total assistance from nurse, slept through entire meal, drank 1 cup of juice, after NP K notified of resident still noted drowsiness, new order noted to discontinue Lexapro 20 mg qd (daily). Review of progress note written by LVN I on 7/15/2022 at 1:36 am revealed: continues with the decrease in Seroquel as ordered with no adverse reaction noted. Continues Lexapro as ordered with no adverse reaction noted. Continues with decrease in Ativan with no adverse reaction noted. Review of progress note written by LVN A at 7/15/2022 at 9:54 am revealed: continues decreased psych meds as ordered, continues Lexapro (ordered 7/4/2022) as ordered no excessive drowsiness or behaviors noted. Review of progress note written by LVN A on 7/16/2022 at 9:57 am revealed: continues decreased psych meds as ordered, continues Lexapro as ordered no excessive drowsiness or behaviors noted. Review of progress note written by RN G on 7/17/2022 at 5:55PM revealed: NP K notified of the resident's continued lethargy. Received new order to discontinue Ativan 0.5mg 1-tab po qd (orally daily). Record review of a progress note dated 7/18/2022 at 1:52am written by LVN F revealed: Continues with decreased in Seroquel as ordered with no adverse reaction. Continues with Lexapro as ordered with no adverse reaction. No adverse reaction to discontinued Ativan. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a progress note dated 7/18/2022 at 7:39AM written by LVN C revealed: day 2 new orders to discontinue Ativan due to increased drowsiness, resident resting in bed at this time. 2:00PM PHD B in the facility at this time made aware of orders to d/c Ativan and Lexapro, he stated that Lexapro does not have a sedative effect but stated to leave this medication discontinued for a week since Resident #50 was still lethargic and he will revisit this medication in 1 week, resident still sleeping a lot but more alert today, LVN C fed him lunch and Resident #50 ate 100%, can normally feed himself when he isn't drowsy, was able to feed himself a lunch roll, drank a full glass of tea. During an interview with LVN C on 8/3/2022 at 6:02 pm it was revealed that Resident #50 was completely different from his baseline. LVN C stated that is why he kept documenting it and reporting it. Record review of a progress note dated 7/19/2022 at 2:49 PM written by PHD B revealed: I saw Resident #50 on this date for follow-up. He overslept today for some reason. Two of his medications were discontinued. When I saw him today, he was still under the influence of oversleeping and had a difficulty expressing his thoughts clearly and reliability. For instance, he was under the belief that his foot had open wounds. Otherwise, he appeared fairly pleasant and cooperative. I (PHD B) provided him with counseling to boost his spirits and reduce depression and anxiety and promote cooperation with all aspects of his treatment. Record review of July 2022 MAR revealed: -Ativan 0.5mg was administered twice daily from 7/5/2022 thru 7/13/2022; except for 7/5/2022 (administered once) and 7/7/2022 (administered once). -Ativan 0.5mg was administered once daily from 7/14/2022 to 7/17/2022 -Lexapro 20mg was administered daily 7/5/2022 to 7/14/2022; except on 7/7/2022. -Seroquel 300mg was not administered twice daily from 7/1/2022 to 7/3/2022 as ordered. 7/2/2022 missed AM dose, 7/3/2022 missed AM dose. -Seroquel 400mg was administered at bedtime from 7/1/2022 to 7/3/2022 as ordered. -Seroquel 400mg was administered twice daily from 7/4/2022 to 7/31/2022; except for 7/7/2022 AM dose. -Seroquel 200mg twice daily as ordered on 7/4/2022 was not administered in the month of July. Order received by LVN C on 7/4/2022 at 1:25 PM by NP K. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/4/2022 at 5:30 PM the DON stated she was unaware of the Resident # 50 receiving the wrong dosage of Seroquel. The process when receiving a new order was for the nurse to put the order in the system. The medication would fire (show up due to be administered) to the MAR and the medication aide or the nurse would administer the medication. The DON and ADON reviewed new order changes and made corrections as needed. The DON stated the pharmacy consultant looked at antipsychotic meds once a quarter and made recommendations for gradual dose reductions. It had not been time for a GDR since the medication changed for Resident #50. The DON did not know why the pharmacist consultant had not attempted a GDR on Resident #4. The DON stated she did not remind the pharmacist or request a GDR from the pharmacist. The DON was unaware of the timeframe GDRs were to be completed. The DON stated taking too much of a psychotropic drug can lead to sedation, drowsiness, and decreased ability to care for oneself. During an interview on 8/4/2022 at 8:20 PM the administrator stated the pharmacist does quarterly medication reviews for all psychotropic medications. The Administrator was unaware of the medication discrepancy with Resident # 50's Seroquel and unaware of the reason no GDR was attempted for Resident #4's Seroquel. The Administrator stated taking too much of a psychotropic medication can cause oversedation, drowsiness, weight loss, and general decline. The Administrator stated it was the responsibility of the nursing department to ensure GDRs were done timely.

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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** 44933 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. There were 2 errors out of 30 opportunities, resulting in a 6.67 percent medication error rate for 2 of 6 residents reviewed for medication error. (Resident #34, Resident #36) The facility failed to ensure Resident #34 received inhalation medications through the correct route of his tracheostomy. The facility administered a discontinued medication to Resident #36. These failures could place residents at risk for inaccurate drug administration. Findings included: 1. Record review of a face sheet dated 8/1/22 revealed Resident #34 was a [AGE] year-old male that admitted to the facility on [DATE] with the diagnoses of multiple sclerosis (nerve damage that disrupts the communication between the brain and the body), acute and chronic respiratory failure (difficulty breathing and the lungs do not get enough oxygen), hypertension (high blood pressure), pneumonia (infection that inflames the air sacs in the lungs and may be filled with fluid or pus), malnutrition (the body does not get enough nutrients), Stage 4 pressure ulcer (wound caused by pressure that has loss of tissue and exposed muscle or bone), and a history of coronavirus 2019. Record review of an admission MDS dated [DATE] indicated Resident #34 was unable to perform the BIMS. Resident #34 was total dependent and required the assistance of two persons for all ADLs. Resident #34 had a tracheostomy (direct airway into the trachea (windpipe) through a surgical incision in the neck). Record review of the physician order report with a date range of 7/01/22-7/31/22 revealed Resident #34's was to receive ipratropium-albuterol sulfate (medication used to relax and open airway passages in the lungs to make breathing easier) 0.5mg/3mg every eight hours by nebulized inhalation and acetylcysteine (thins or dissolves mucus in the lungs) 400 mg by inhalation every eight hours. During an observation on 8/01/22 at 12:42 PM observed LVN W remove a mask with a nebulizer (device to deliver aerosol medication) attached from over Resident #34's nose/mouth and the resident had a tracheostomy (artificial airway made through the lower neck). During an observation and interview on 8/01/22 at 4:29 PM with LVN W, she said she was giving Resident #34 a nebulizer treatment with ipratropium-albuterol and his acetylcysteine by inhalation. The resident had a mask over his nose and mouth with a nebulizer attached. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/01/22 at 6:05 PM with LVN W, she said she had been employed with the company for 2 months as the corporate mobile staffing nurse, but she had worked for the company since 2018 as an agency staffing nurse. She said she did not know any other way to give Resident #34's breathing treatment except over his nose/mouth, because he also had to have his oxygen on at all times, so his oxygen wouldn't drop. Surveyor asked LVN W how was Resident #34 inhaling the medication when the mask was over his nose/mouth, and he breathed through his tracheostomy located in his lower neck? LVN W said, you do not think he can get it through his nose? She then said, I get what you are saying, and he probably should have an attachment for the tracheostomy to give his breathing treatments. She said she had been checked off on tracheostomy care at another company facility and she had been providing care to residents with tracheostomies for a long time. During an interview on 8/02/22 at 9:59 PM with LVN Y, she said she had been administering Resident #34's nebulized inhalation treatments with a mask over his nose/mouth, since the resident was admitted to the facility. She said she was just told the facility was ordering the attachment to be able to administer the inhalation medications through his tracheostomy. During an interview on 8/03/22 at 11:11 AM with LVN Z, she said she had been administering Resident #34's nebulized inhalation breathing treatments by putting the medication in the nebulizer and placing the face mask on his face. She said she made sure his head was elevated to ensure he was getting the medication. Surveyor asked LVN Z how she was ensuring the medication was reaching the resident's lungs through the face mask over his nose/mouth, when he breathed through his tracheostomy in his neck. She said she was told this week they had ordered an adapter so they could administer the inhalation medications through the tracheostomy mask. She said if Resident #34 was not getting the inhalation breathing treatment medications to his lungs, it could affect his breathing. During an interview on 8/04/22 at 7:00 PM with the DON, she said a resident with a tracheostomy would not receive the medication in the nebulizer treatment by inhalation when the mask was placed over the nose/mouth, because the resident breathed through the tracheostomy in the neck. She said the resident would not receive the benefits of the medication. She said she was working on ordering an adapter to be able to administer the nebulized inhalation medications through the tracheostomy. 2. Record review of the face sheet dated 8/4/22 revealed Resident #36 was [AGE] years old, male, and admitted on [DATE] with diagnoses including senile degeneration of brain (a decrease in cognitive abilities or mental decline), Dementia with behavioral disturbance, and nutritional anemia (the body is not absorbing enough iron, folate, or vitamin B-12 from the diet). Record review of the MDS dated [DATE] revealed Resident #36 was usually understood and usually understood others. The MDS revealed Resident #36 had a BIMS of 4 which indicated severe cognitive impairment and required extensive to total dependence for ADLs. Record review of the care plan dated 7/12/22 revealed Resident #36 was at risk for abnormal labs related to medication, disease processes, and a history of abnormal labs. Intervention included give medication as ordered by physician. Record review of the consolidated physician orders dated 8/4/22 revealed Folic acid 1mg, 1 tablet oral once a day dated 3/27/22-6/15/22. During an observation on 8/2/22 at 9:30 a.m. CMA EE administered Resident #36: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Depakote ER; 250 mg; 1 capsule; oral; once a day (morning 7:00am-10:00am) Benztropine; 1 mg ;1 tab; oral; twice a day (morning 7:00am-10:00am, bedtime 7:00pm-10:00pm) Keppra; 750 mg;1 tab; oral; twice a day (morning 7:00am-10:00am, bedtime 7:00pm-10:00pm) Potassium Chloride; 20 mEq; 1 tab; once a day (morning 7:00am-10:00am) Folic acid; 1 mg; 1 tab; oral once a day (morning 7:00am-10:00am) dated 3/27/22-6/15/22. Risperidone; 2 mg; 1 tab with breakfast; oral; once a day (morning 7:00am-10:00am) Colace; 100 mg; 1 tab; oral; once a day (morning 7:00am-10:00am) Xanax; 0.5 mg; oral; twice a day (morning 7:00am-10:00am, bedtime 7:00pm-10:00pm) Rivastigmine; 9.5 mg; 1 patch; transdermal; once a day (morning 7:00am-10:00am) During an interview on 8/3/22 at 9:19 a.m., CMA EE said she was the only medication aide for 62 residents. She said a couple of months ago, the company switch to a liberalized medication schedule (specified time frames for medication administration) which meant morning medication had to passed out between 7am-10am. She said she asked for permission to give medications 1 hour before 7am and 1 hour after 10 am, to try to not administer medications late. She said the facility denied her request and she knew the company was phasing out her position as a CMA. She said they offered her to return being a CNA again which was not happening. She said it was impossible to administer all the medications on time especially because a lot of residents wandered or refused medication. She said the facility wanted her to start med pass on the secured unit, where Resident #36 resided, first and wanted her done in 1 hour. She said she was probably rushed and forgot Resident #36's folic acid was discontinued. She said she should be following the electronic charting system and not doing it by memory. She said giving a resident a medication they no longer need could affect their lab levels or make them sick. She said she was also not following physician's orders by giving a discontinued medication. During an interview on 8/3/22 at 4:30 p.m., this surveyor asked the regional nurse for CMA EE's competencies on medication administration. The competencies were not provided before or after exit of the survey. During an interview on 8/4/22 at 5:49 p.m., the DON said the facility only had one med aide. She said they recently switched to liberalized med times hoping it would help with late administration. She said the old way caused late administration. She said it did not excuse CMA EE from administering Resident # 36 a discontinued medication. She said if she followed the MAR, she would have noticed it had been discontinued for a while. She said she hoped this medication error was a one-time incident. She said she expected nurses and CMAs to check orders before administering medication. She said given giving a discontinued medication could harm the resident because obviously the physician discontinued it for a reason. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/4/22 at 6:30 p.m., the Administrator said medication errors could cause a lot of different effects on residents. She said if they are given something that is not ordered, it could cause organ damage and even death. She said not getting medications could cause the resident to have seizures, blood clots, high blood pressure and sugar, and even death if it is not corrected. Record review of a facility Administering Medication policy dated April 2019 revealed .medications are administered in a safe and timely manner, and as prescribed .only person licensed or permitted by this state to prepare, administer and document the administration of medications may do so .the individual administering the medication document in the resident's electronic record after administering each medication .the individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .medications errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 46299 Based on observation, interview and record review, the facility failed to provide a storage area that appropriately locked for the storage of medication and biologicals that were accessible only to authorized personnel for 1 of 2 medication rooms reviewed for medication storage. This could have allowed any of the 30 independently mobile residents (9 of those are cognitively impaired) out of 62 total residents in the facility, access to medications not prescribed to them. The facility failed to ensure the front hall medication room had a working locking/latching mechanism; the area was not consistently supervised by nursing staff. This failure could leave medications and supplies accessible to unauthorized persons and residents. Findings included: Observation on 08/04/22 at 01:37 and at 03:36 PM of the front hall medication room revealed that the medication room was not locked or latched. The nursing staff was not in the area, multiple residents were in the dining room, and roaming the hallways with the medication room door unattended. Upon examination of the door, it was noted that the deadbolt did not activate appropriately, and the door did not latch appropriately. There were stock medications, the secured Emergency medication kit and the following: Multiple bottles of various types of Vitamins (Vitamin B12, Vitamin D3, Thiamine (B1), etc.) 2 Bottles of Guaifenesin (expectorant) 2 Bottles of Ibuprofen (Nonsteroidal anti-inflammatory medication) 2 Boxes of Omeprazole (acid reflux medication) 1 Bottle and 3 insulin pens of Novolin R, Lantus, Humalog and Novolog insulin (synthetic insulin that decreases blood sugar) 2 Boxes of Risperdal (antipsychotic medication) 8 Cards of Divalproex (anticonvulsant medication) totaling 240 capsules Requested the maintenance log for the last 5 months for the facility from the Administrator and DON on 08/04/22, did not receive. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/04/22 at 03:41 PM with LVN Z, she stated the medication storage room on the front hall had not been locking/latching correctly for about 5 months. She stated, I do not know if the DON or Administrator knew the door was not locking/latching for the last 5 months, but the maintenance man had knowledge of the issue, she knew that because she had told him herself at one point. The front hall medication room should be a secured door, or any resident can get to the medications in it because staff were not always around the nurse's desk and medication room when caring for residents. There were a lot of residents that come to the dining area and roam the hallways. Interview on 08/04/22 at 03:43 PM with DON stated I did not know the medication room door was not functioning correctly, and I do not know why the nurses did not tell me the medication door was not latching/locking. The staff can request maintenance to fix this sort of issue verbally or with a maintenance request, I do not know if this was completed. The population of residents the facility has are primarily psych residents along with Dementia/Alzheimer's (memory disfunction) diagnosed residents, so that medication room door should always be secured. It poses a huge risk to the residents, since there were ambulatory residents in hallways and the medication room area at times. Attempted interview on 08/04/22 at 04:21 PM and 04:43 PM with Maintenance Director by phone revealed no answer, voicemail full, unable to leave a message. Record review of the 11/2020 facility Storage of Medications Policy revealed the facility stores all drugs and biologicals in a safe and secure manner. Only persons authorized to prepare and administer medications have access to locked medications. The nursing staff is responsible for maintaining medication storage and preparation areas in a safe manner. Compartments (including, but not limited to, rooms) containing drugs and biologicals are locked when not in use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46062 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. The facility failed to ensure storage lid was secured on container. The facility failed to ensure the scoop was not left in the food storage container. The facility failed to ensure food was stored properly in the dry pantry and the freezer. The facility failed to label and date stored food in the dry pantry and the freezer. The facility did not keep the ceiling air vent cover clean in the kitchen. The facility failed to ensure kitchen staff wore their masks properly. The facility failed to serve food in a sanitary manner. These failures placed residents at risk of food-borne illness. Findings included: During an observation in the kitchen on 8/01/22 starting at 9:00 AM revealed the ceiling air vent located above the walkway in front of the steam table and food preparation area had a fuzzy brown/gray substance covering the air vent and had approximately a one- inch separation from the ceiling on one end of the vent; one vent above the steam table had brown and grey discoloration to the vent and ceiling around vent; the Wonder Bar juice spout and holder were noted to have a thick sticky substance on them; the stove top had black/brown grease like substance on the back and side walls; approximately 8 cookie sheets and pans with carbon build up; QCS Convection system with wire conveyor had brown/black grease like substance and food particles in the conveyor; and Cook S was wearing his mask below his chin. During an observation in the kitchen pantry on 8/01/22 starting at 9:17 AM revealed large bags of cornflake cereal, crisp rice cereal, and toasted oats cereal loosely folded over with a metal clip on one corner and was not tightly secured; a large bag of fruit swirls cereal with a cut down the center of the bag was loosely folded over and not secured tightly; an open bag with tea bags exposed; an opened bag of white cake mix in an open zip lock bag; four large cans of Heinz ketchup and three large cans of Heinz spaghetti sauce were not dated; one plastic container of creamer with the lid not tightly secured; and one large plastic container of sugar with a scoop in it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation of the kitchen freezer on 8/01/22 at 9:25 AM revealed an open bag and two closed plastic bags of what appeared to be sliced garlic bread not labeled or dated; an opened bag of freezer burned meat, which was not labeled or dated; a zip lock bag of freezer burned meat, which was not labeled or dated; a large bag of breaded meat with the open end of the bag twisted closed and not secured, labeled or dated; 5 bags of what appeared to be breaded okra not labeled or dated; and a blue trash-like bag of what appeared to be mixed vegetables with the end of the bag tied in a knot and was not labeled or dated. During an observation in the kitchen on 8/01/22 at 9:33 AM revealed a large area of missing tile in front of the dishwasher and missing paint and dry wall with metal showing on the edge of the wall closest to the floor by the steam table. During an observation in the kitchen on 8/01/22 at 9:37 AM revealed Dishwasher T wearing his mask below his chin while putting newly delivered food in the freezer. During an observation in the kitchen on 8/02/22 at 11:43 AM revealed Cook S with his mask below his chin standing at the steam table over food wearing gloves; observed him unroll brown paper towels and tear off paper towels and wipe his sweaty forehead and face wearing gloves and proceeded to take the temperatures of the food on the steam table without changing his gloves. During observations in the kitchen on 8/02/22 from 12:00-12:28 PM revealed Cook S began plating residents' food; observed Cook S grab the front of his mask with his gloved hand and repositioned his mask and returned to serving/plating resident's food without changing his gloves or washing his hands; observed Cook S wipe the sweat from his forehead and face with the bottom of his white t-shirt exposing his abdomen (belly) and then pulled up his pants with both gloved hands and did not change gloves or wash his hands and he resumed serving the residents' food; observed Cook S wipe his forehead/face with the bottom of his t-shirt three additional times and did not change his gloves or wash his hands and resumed serving the residents' food; observed Cook S pour pureed pinto beans into a bowl and some of the pureed beans ran down the side of the bowl, Cook S took his gloved finger and wiped the pureed beans up the side of the bowl and scraped the pureed beans back into the bowl with same gloved finger used previously to wipe his forehead/face with his t-shirt and sent out on the cart to be served to the residents. On 8/02/22 at 2:15 PM, attempted to interview Cook S, but the Dietary Manager said he had already left the facility, he had a second job that he started at 1:00 PM and he was not due to return to the facility until 8/05/22. On 8/03/22 at 2:05 PM, attempted to contact Cook S by phone with no answer and voice mail was full and was not able to leave a message. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/03/22 at 5:24 PM with Dishwasher T, he said he had worked at the facility for almost three months, and he was in training to become a cook. He said his job duties included washing dishes, setting up trays, making coffee and tea, checking, and logging the temperatures of the dishwasher, prepared desserts, helped with stocking the delivered food/goods, stocked the freezer and the storeroom. He said staff should wear a mask, hair net, beard guard, gloves, and an apron in the kitchen. He said the mask should cover your nose and mouth when worn. He said staff should change gloves after touching their mask. He said it could contaminate the resident's food if staff touch their mask and don't sanitize. He said he puts open cereal in a plastic bag and zip locks it to keep it fresh and keep anything from getting in the cereal. During an interview on 8/03/22 at 5:34 PM with Dishwasher U, he said he had worked at the facility for only 2 days, but he had worked at the facility previously. He said his duties included washing dishes, preparing desserts, setting up the residents' food trays with silverware, condiments, and drinks. He said he was required to wear a mask, apron, and gloves while in the kitchen. He said staff should take gloves off, sanitize hands, and get new gloves if they were to touch their mask or anything that could contaminate the residents' food. He said staff should not handle mask or personal clothing while in the kitchen without changing gloves, washing their hands, and putting on new gloves. He said staff should not handle clothing while serving food, because it could contaminate the residents' food. On 8/03/22 at 5:38 PM, attempted to contact Cook S by phone with no answer and voice mail was full and was not able to leave a message. During an interview on 8/03/22 at 5:42 PM with the Dietary Manager with the Regional Area Dietary Manager present, she said she had worked at the facility for about three years and almost a year as the Dietary Manager. She said all food should be labeled and dated and tightly secured to promote freshness and prevent contamination. She said kitchen staff should wear, gloves, mask, beard guards, and hair nets in the kitchen. She said the staff's mask should always be worn over the nose and mouth. She said staff should not touch their mask or personal clothes without removing gloves, washing their hands, and putting on new gloves before continuing to serve the residents' food. She said staff should definitely not use their t-shirt to wipe their face without removing their gloves, washing their hands, and applying new gloves prior to continuing to serve the residents' food. She said they had seen Cook S wipe his face with the front of his t-shirt yesterday during meal service and they already had plans to start in-services on proper hygiene in the kitchen and when to remove gloves, handwashing, etc . She said it was her responsibility to ensure the kitchen staff were trained on proper hygiene and sanitation in the kitchen. She said kitchen staff not using proper hygiene could cause cross contamination and could cause the residents to get sick. During an interview on 8/04/22 at 7:34 PM with the Administrator, she said she would expect the kitchen to be kept sanitary and the kitchen staff to practice good sanitary food preparation and storage to prevent illness to the residents . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a facility Glove Use policy not dated revealed .single use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from the food handlers' hands to the food product being served . gloves are just like hands . they get soiled . anytime a contaminated surface is touched, the gloves must be changed . during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks . after engaging in other activities that may possibly contaminate the hands with bodily fluids . wash hands after removing the gloves . Record review of a facility Preventing Foodborne Illness titled Employee Hygiene and Sanitary Practices policy not dated revealed .culinary service employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness . all employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness . employees will demonstrate knowledge and competency in these practices prior to working with food or serving to residents . Record review of a facility Preventing Foodborne Illness titled Food Handling policy not dated revealed . food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized . the facility recognizes that the critical factors implicated in foodborne illness are poor personal hygiene of food service employees contaminated equipment . all employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness . employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents . all food service equipment and utensils will be sanitized according to current guidelines and manufactures' recommendations . Record review of a facility Food Preparation and Service policy not dated revealed . culinary service employees shall prepare and serve food in a manner that complies with safe food handling practices . food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illnesses . Record review of a facility Food Receiving and Storage policy not dated revealed . foods shall be received and stored in a manner that complies with safe food handling practices . all foods stored in the refrigerator or freezer will be covered, labeled and dated . dry foods that are stored in bins will be removed from the original packaging, labeled and dated . wrappers of frozen foods must stay intact until thawing . Record review of a facility Refrigerators and Freezers policy not dated revealed . this facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines . all food shall be appropriately dated to ensure proper rotation by expiration dates . received dates will be marked on cases and on individual items removed from cases for storage .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 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 4 of 21 residents reviewed for transmission-based precautions. (Resident #34, Resident #52, Resident #111, and Resident #211) The facility failed to prevent cross-contamination while providing tracheostomy and wound care on Resident #34. The facility failed to exercise infection control on Resident #34 when reattaching his humidifier tubing after it was on the floor. The facility failed to change wound dressings daily as ordered on Resident #34. The facility failed to change PICC line dressing within timeframe for Resident #52. The facility failed to protect Resident #111 from possible respiratory infection by staff not wearing their masks properly. The facility failed to maintain isolation status of new non-vaccinated admitted Resident #211. The facility failed to inform all staff of isolation status of Resident #211. The facility failed to ensure all staff were wearing masks properly in the facility. These failures could place residents at risk for being exposed to health complications and infectious diseases. Findings included: 1. Record review of a face sheet dated 8/1/22 revealed Resident #34 was a [AGE] year-old male that admitted to the facility on [DATE] with the diagnoses of multiple sclerosis (nerve damage that disrupts the communication between the brain and the body), acute and chronic respiratory failure (difficulty breathing and the lungs do not get enough oxygen), hypertension (high blood pressure), pneumonia (infection that inflames the air sacs in the lungs and may be filled with fluid or pus), malnutrition (the body does not get enough nutrients), Stage 4 pressure ulcer (wound caused by pressure that has loss of tissue and exposed muscle or bone), and history of coronavirus 2019. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an admission MDS dated [DATE] indicated Resident #34 was unable to perform the BIMS. Resident #34 was total dependent and required the assistance of two persons for all ADLs. Resident #34 was always incontinent (unable to control) of bowel and he had a foley catheter (tube into the bladder to drain urine). Resident #34 had a tracheostomy (direct airway into the trachea (windpipe) through a surgical incision in the neck). Resident #34 was unable to communicate with others. Resident #34 had diagnoses of anemia (a condition where the blood does not have enough healthy red blood cells), hypertension (high blood pressure), GERD (gastroesophageal reflux disease-digestive disease in which stomach acid flows into the food pipe and irritates the lining), pneumonia, malnutrition, acute and chronic respiratory failure, stage 4 pressure ulcer, and osteomyelitis (infection of the bone) of sacral and sacrococcygeal region (bottom of the spine and the tailbone). Resident #34 had three stage 2 pressure ulcers (wound caused by pressure with loss of the top two layers of skin). Resident #34 had one unstageable pressure ulcer (wound caused by pressure and the extent of the wound could not be visualized). Resident #34 had a pressure reducing mattress on his bed. Resident #34 had a feeding tube (tube placed into the stomach to provide nutrition). Record review of Resident #34's care plan with admitted [DATE] revealed it did not address the resident's multiple disease processes of anemia, hypertension, GERD, pneumonia, malnutrition, acute and chronic respiratory failure, stage 4 pressure ulcer, and osteomyelitis of sacral and sacrococcygeal region. Resident #34's care plan revealed it did not address the resident's pressure ulcers or risk of developing additional pressure ulcers. Resident #34's care plan revealed it did not address he had a tracheostomy or the care of the tracheostomy. Record review of Resident 34's physician order report with date range of 7/1/22-7/31/22 revealed an order for tracheostomy care to be performed every shift and as needed; and orders to perform wound care daily to left heel, left hip, left ischium (area of the pelvis that forms the lower and back part of the hip), sacrum and there was no order for wound care to left shoulder. During an observation on 8/01/22 at 5:22 PM revealed Resident #34's humidifier tubing was not unattached to the resident's tracheostomy and was laying in the floor beside the bed, while LVN W and TCNA V changed the bedding on the resident's bed. Surveyor observed LVN W and TCNA V turn resident from side to side and the wound dressing to the resident's left shoulder was dated 7/30/22 and his left heel dressing was dated 7/30/22 and the other wound dressings had already been removed. At 5:26 PM, Resident #34 begun coughing large amounts of yellow mucus from his tracheostomy, LVN W then realized the tubing was not attached to the tracheostomy mask and picked the tubing off the floor and reattached the tubing to the tracheostomy mask. LVN W proceeded to remove the saturated gauze sponge from around the tracheostomy tube and placed with a clean gauze spouge around the tracheostomy tube wearing the same gloves. LVN W then began to cleanse the sacrum wound with cleanser and gauze sponges, then applied calcium alginate (promotes wound healing), and then covered the wound with a dressing without changing her gloves after handling the saturated tracheostomy gauze sponges. LVN W then removed her gloves and wrote the 8/01/22 and her initials on the dressing . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of a face sheet dated 8/04/22 revealed Resident #52 was a [AGE] year-old male that was admitted [DATE] with the diagnoses of arthritis (joint pain) of right shoulder due to bacteria, infection of right shoulder, left knee pain, diabetes (disease where there is too much sugar in the blood), bipolar (disorder with episodes of mood swings ranging from depressive lows to manic highs), anxiety (intense, excessive, and persistent worry and fear about everyday situations), hypertension, coronary heart disease (damage or disease in the heart's major blood vessels), chronic obstructive pulmonary disease (disease of the lungs that block airflow and make it difficult to breathe), fracture of right upper arm, MRSA (methicillin resistant staphylococcus aureus) infection, reduced mobility, need for assistance with personal care, and pain in right shoulder. Record review of an admission MDS dated [DATE] indicated Resident #52 had a BIMS of 15, which indicated he was cognitively intact. Resident #52 required extensive assistance of one to two person for most ADLs, except was total dependent on two persons for bathing. He required supervision and assist of one person for locomotion and eating. He used a wheelchair for mobility. Resident #52 was occasionally incontinent (no control) of urine and frequently incontinent of bowel. Resident #52 had diagnoses of anemia, hypertension, coronary artery disease, diabetes, anxiety, bipolar, chronic obstructive pulmonary disease, fracture of right upper arm, and arthritis. Resident #52 had frequent pain and had a history of fall with injury. Resident #52 was at risk for developing pressure ulcers and he had a surgical wound. Resident #52 was receiving antipsychotic, antibiotic, opioid, and intravenous (in the vein) medications. Resident #52 was receiving occupational and physical therapy at the facility. Record review of the Resident #52's care plan with admitted [DATE] revealed it did not address the resident's multiple disease processes of anemia, hypertension, coronary artery disease, diabetes, anxiety, bipolar, chronic obstructive pulmonary disease, fracture of right upper arm, and arthritis. Resident #52's care plan did not address he was receiving intravenous antibiotics through a PICC line (peripheral inserted central catheter-tube inserted in a vein in an arm or leg, used for long-term intravenous medications) or care of the PICC line. Resident #52's care plan did not address he had an infection to right shoulder. Record review of Resident #52's resident progress notes dated 8/4/22 revealed LVN C documented 6/29/22 the resident arrived at the facility from the hospital with a PICC line in the left arm for intravenous medication for infection to right shoulder. Record review of Resident #52's active physician orders not dated revealed there was no order for PICC line dressing changes. During an observation and interview on 8/01/22 at 11:37 AM with Resident #52, he said he had been at the facility for about a month with a bad infection in his shoulder from a surgery. Resident had a PICC line to his left upper arm with date of 7/28/22 and gauze covering the insertion site. During an observation on 8/04/22 at 11:10 AM, revealed Resident #52 had a dirty gauze covering the catheter insertion site of his PICC line with a clear dressing dated 7/28/22 covering the gauze. Resident #52 said the nurse said she would be changing it that day, but he had been told that before. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with on 8/04/22 at 4:20 PM with LVN Z, she said PICC line dressings should be changed weekly. Surveyor asked LVN Z to show where the PICC line dressing changes were documented in their system for Resident #52. She said it should be documented on the treatment flowsheet and when she looked in the system, she said there was not an order for the dressing changes, and she could not show surveyor the documentation. She said he should have had orders for his PICC line dressing changes upon admission, but there were no orders in the system. 3. Record review of a face sheet dated 8/02/22 revealed Resident #111 was a [AGE] year-old male that was admitted [DATE] with the diagnoses of dementia (forgetfulness), weakness, respiratory failure, history of a brain injury from trauma, fracture of left upper leg, pain, chronic obstructive pulmonary disease, and anxiety. Record review of Resident #111's quarterly MDS dated [DATE] revealed he had a BIMS of 7, which indicated he was severely cognitively impaired. He required supervision with setup for most ADLs and assistance of one for dressing and personal hygiene. 4. Record review of a face sheet dated 8/02/22 revealed Resident #211 was a [AGE] year-old male that was admitted on [DATE] with the diagnoses of cerebral infarction (stroke-caused by lack of blood supply to the brain and causes parts of the brain to die), chronic obstructive pulmonary disease, weakness, lack of coordination, diabetes, hypertension, heart failure, and fall with injury to the face. Record review of Resident #211's admission MDS dated [DATE] revealed he had a BIMS of 15, which indicated he was cognitively intact. Resident #211 required supervision or limited assistance of one person for most ADLs and walked with a walker or assistance of one person. Resident #211 was admitted from the community. Record review of Resident #211's resident progress notes dated 8/4/22 revealed the DON documented 7/26/22 upon admission, the resident was not vaccinated for covid and would have to quarantine for fourteen days and his test for covid was negative upon admission. Resident #211 was admitted from home and arrived by private vehicle. On 8/02/22 at 7:46 AM, LVN A documented the resident was up in the dining room that morning and she asked the administration about the resident's isolation status and checked his admitted . She then escorted Resident #211 back to his room and reminded him of his isolation protocol and precautions related to his admission. On 8/04/22 at 10.25 AM, LVN Z documented the resident remained on isolation. During an observation on 8/01/22 at 11:00 AM revealed TCNA V came out of a resident's room into the hallway with her mask below her chin. During an observation on 8/01/22 at 11:51 AM revealed TCNA V sitting in hallway with her mask pulled down under her chin while charting on the wall system. During an observation on 8/01/22 at 12:17 PM revealed Resident #211 was in a room outside the covid unit and there was not an isolation sign on his door or a PPE cart outside his room. During an observation on 8/01/22 at 4:30 PM revealed TCNA V pushed Resident #111 down the hallway with her mask below her nose and sat down to chart in the hallway and pulled her mask down below her chin with Resident #111 sitting beside her. Resident #111 was not wearing a mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/01/22 at 6:05 PM LVN W, she said she had been employed with the company for two months as their corporate mobile nurse, but she had worked for them since 2018 as an agency staffing nurse. She said she picked the tubing off the floor in a hurry because the Resident #34 needed his oxygen quickly and she did not want his oxygen level to drop. She said she did change her gloves after removing the gauze from Resident #34's tracheostomy and before starting the wound care to his sacrum. She said, you did not see me do it? She said she changed her gloves between each wound too, because she could transfer bacteria from his tracheostomy to his wounds or from wound to wound. During an observation on 8/02/22 at 7:25 AM revealed Resident #211 in the dining room without a mask on. After approximately thirty minutes, LVN A came over to the Resident #211 and told him he had to go back to his room because he was on isolation. She then put a N95 mask on the resident pushed him in his wheelchair back to his room. During an observation on 8/02/22 at 10:02 AM revealed TCNA V walking down the hallway with her surgical mask pulled down below her chin. During an observation and interview on 8/02/22 at 11:25 AM revealed the Regional Dietary Manager entered Resident #211's room wearing a surgical mask and visited with Resident #211. Resident #211 was not wearing a mask. There was not a sign on the door that indicated isolation status. She said Resident #211 was her brother-in-law. She said he was in quarantine since he was a new resident and was not vaccinated. During an observation on 8/02/22 at 12:33 PM revealed TCNA V delivered a meal tray to Resident #211 who was supposed to be in quarantine, wearing only a surgical mask. Resident #211 was not wearing a mask. During an interview on 8/02/22 at 4:50 PM with the DON, who was also the Infection Preventionist, she said it was the facility's policy to quarantine new admitted unvaccinated residents for fourteen days and fully vaccinated residents did not have to quarantine if they had no symptoms . She said residents were instructed on their quarantine status when they were admitted . She said new residents were tested upon admission and all staff/residents were tested every Tuesday and Thursday. She said staff should be wearing full PPE with a N95 mask on the warm (residents with unknown Covid exposure status) and hot (residents known to be positive for Covid) covid unit. She said if staff were not wearing the proper PPE, they could spread COVID to other residents/staff. She said she was responsible to ensure staff were trained on infection control policies and procedures. She said she had been the DON for four months and was still learning the processes to ensure staff and residents are following correct infection control procedures. She said the admitting nurse should ensure a new admitted resident that was placed in isolation had the proper PPE and Isolation sign on the door. During an interview on 8/03/22 at 11:12 AM LVN Z, she said newly admitted non-vaccinated residents must be isolated for fourteen days and the residents were told on admission about their isolation status. She said staff must wear full PPE, gown, gloves, N95 mask, face shield/goggle, and gloves on the Covid unit. She said non-vaccinated new residents on isolation require staff to just wear a regular mask and gloves in the resident's room. She said the PPE carts are kept stocked and should be outside the door of the isolated resident. During an observation on 8/03/22 at 11:20 AM revealed the Regional Dietary Manager entered Resident #211's room wearing only a surgical mask and stood in front of the resident to visit with him. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/03/22 at 11:40 AM with Resident #211, he said he had not been told he was on isolation until yesterday when he went to the dining room. He said no one had told him when he was admitted to the facility. During an interview on 8/03/22 at 11:42 AM with Housekeeper AA, he said he had worked at the facility for five years. He said there usually was a sign on the door if a resident was on isolation and there would be a PPE cart outside the resident's door. He said staff would need to wear full PPE, gown, face shield/goggles, gloves, and N95 mask on the Covid unit. He said if a resident was on warm unit, you would treat the resident like they had Covid and wear full PPE in the resident's room. He said there was no one on isolation now. He said he was not aware that Resident #211 was on isolation, and he had just cleaned his room wearing just a surgical mask and gloves. He said there was not a Stop see nurse sign on the door or a PPE cart outside the resident's door, and the resident's room was just outside of the red zone. He said the red zone was the covid isolation resident rooms. During an interview on 8/03/22 at 5:11 PM with CNA BB, she said she had worked at the facility for nine years. She said the charge nurse usually told her if a resident was on isolation. She said residents on isolation should have a sign on the door and a PPE cart outside the door. She said residents on the warm hall should be on isolation and staff would be required to wear full PPE, which consisted of gowns, gloves, face shield, and a N95 mask just as if the resident had covid. During an interview on 8/04/22 at 08:40 AM with Resident #211's family member, she said she was with Resident #211 during the admission process and her and the DON told Resident #211 that he would have to be in isolation for 10 days, because he was a new admission and was not fully vaccinated against Covid. She said Resident #211's memory was bad, and he forgets a lot of things and often could not remember what happened yesterday. She said she did not know she should have been wearing full PPE with a N95 mask. She said there was usually a sign on the door when someone was on isolation. She said she knew Resident #211 was on isolation, but she guessed she did not even think about it because he was her family member. During a phone interview on 8/04/22 at 06:04 PM with TCNA V, she said residents on isolation would have a STOP see nurse sign on the door and a PPE cart outside the door. She said new residents admitted on the warm hall, should be treated the same as the residents with hot covid hall by wear full PPE, which consisted of gown, gloves, N95 mask, and face shield. She said she did not know Resident #211 was on isolation, because there was not a sign on the door and there was not a PPE cart outside the door. She said she did not realize she had pulled her mask down under her chin in the hallways. She thought she must have been hot. She said staff could spread germs if they do not wear the proper PPE. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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 - Few	During an interview on 8/04/22 at 7:00 PM the DON, she said it would be an infection control issue if the humidifier tubing was on the floor and then hooked back up to the resident without first disinfecting it. She said it would also be an infection control issue if the nurse did not change gloves between removing a mucus saturated dressing from around a tracheostomy and then replacing with a clean dressing. The DON said it would be an infection control issue if the nurse did not change her gloves before performing wound care to the residents open wound on his sacrum after handling a mucus saturated tracheostomy gauze. She said Resident #34 already had an infection. She said residents on isolation should have a sign on the door and a PPE cart outside the door. She said Resident #211 was the only resident on isolation because he was not being fully vaccinated and was new admit. She said she was not aware there was not a sign or PPE cart outside Resident #211's door, who was a new non-vaccinated admission was supposed to be on isolation. The DON said she was unaware that staff were unaware of Resident #211's isolation status and they were not wearing proper PPE when entering his room. She said it was an infection control issue if staff were not wearing proper PPE and if he had covid, then staff could spread it to other residents and staff. The DON also said staff should be wearing their masks over their nose and mouths at all times, to prevent the spread of infection. During an interview on 8/04/22 at 7:34 PM with the Administrator, she said she was not a nurse, but she would expect nurses should wear clean gloves when moving from dirty to clean areas or when changing to another area of the body during wound care treatments. She said residents were placed in isolation upon admission if they were not fully vaccinated and should be isolated for 14 days. She said nonvaccinated newly admitted residents should be treated as if they had covid and staff should be wearing full PPE: gowns, gloves, N95 mask, and face mask or goggles. She said if staff do not wear proper PPE, they could spread covid, if the resident was positive for covid. Record review of the facility's infection control policy titled Infection Prevention and Control Program dated of October 2020 revealed, . infection prevention and control program was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . each center should refer to and follow CDC guidance and their stat guidance for infection prevention and control . Texas Health and Human Services, COVID-19 Response for Nursing Facilities most current version, should be referred to and followed by centers located in the state of Texas . infection prevention and control program was a facility wide effort involving all disciplines and individuals and was an integral part of the quality assurance and performance improvement program . elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety . important facets of infection prevention include: educating staff and ensuring that they adhere to proper techniques and procedures, implementing appropriate isolation precautions when necessary . the facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers including: precautions to prevent these individuals from contracting infections/virus from residents or others, the facility provides personal protective equipment, checks for its proper use . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's infusion therapy procedures policy titled Dressing Change for Vascular Access Devices, dated 08/16, revealed . to prevent local and systemic infection related to the intravenous catheter . transparent semi-permeable membrane dressings are changed every 7 days and as needed . if a BioPatch is applied under the transparent dressing, change the dressing every 7 days . initial dressings after catheter placement will be changed as needed if saturated, and 24-48 hours after insertion of midlines, PICCs, or other central venous access devices if gauze is present under the dressing and/or there is blood/drainage under the dressing . Record review of the facility's wound care policy titled Wound Care dated June 2022 revealed . purpose of this policy was to provide guidelines for the care of wounds to promote healing . perform hand hygiene . put on clean gloves, loosen tape and remove dressing . pull glove over dressing and discard into appropriate receptacle . perform hand hygiene . put on clean gloves . wash wound in a circular motion from inside out with ordered wound cleanser and gauze . apply treatment and dress wound as ordered by physician . mark tape with initials, time, and date and apply to dressing . Record review of the facility's covid response policy titled COVID-19 Response for Nursing Facility dated 6/27/22 revealed . all residents who are not up to date with COVID-19 vaccine doses and are new admissions or readmissions to the facility or a resident who has gone overnight should quarantine, even if they test negative upon admission . NIOSH-approved N95 or equivalent or higher level respirators can be used by healthcare providers where additional risk factors for transmission are present such as the patient is not up to date with all recommended COVID-19 vaccine doses . Record review of the facility's personal protective equipment policy titled Using Face Masks dated September 2010 revealed . to guide the use of masks . to prevent transmission of infectious agents through the air . protect the wearer from inhaling droplets . be sure that face mask covers the nose and mouth while performing treatment or services for the patient .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 44933 Based on observation, interviews, and record review, the facility failed to be adequately equipped to allow residents to call for staff through a communication system which relays the call directly to a centralized staff work area for 5 of 18 residents reviewed for call lights. (Resident #10, Resident #20, Resident #43, Resident #46, Resident #49) The facility failed to ensure Resident #10, Resident #20, Resident #43, Resident #46, and Resident #49 had functioning call lights. This failure could place residents at risk of injury that could lead to possible falls, major injuries, hospitalization , and unmet needs. Findings Included: 1. Record review of a face sheet dated 8/1/22 revealed Resident #46 was a [AGE] year-old male, that admitted to the facility on [DATE] with the diagnoses of weakness, history of a displaced fracture of left tibial tuberosity (lower leg), glaucoma (the nerve connecting the eye to the brain is damaged from high eye pressure), difficulty sleeping, and coronavirus 2019. Record review of the admission MDS dated [DATE] indicated Resident #46 had a BIMS of 12, which indicated the resident was cognitively intact. Resident #46 required extensive assistance of one to two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene (combing hair, brushing teeth, shaving, washing/drying face and hands). Resident #46 required total dependence of 2 persons for bathing. Record review of the resident progress notes dated 8/02/22 revealed the DON documented on 7/18/22 that the Resident #46 had completed his isolation status for Covid and was ready to be moved. During an observation and interview on 8/01/22 at 12:01 PM with Resident #46, he said he could not stand up since he fractured his lower leg. Resident #46 had a private room, and both call light buttons were observed in the floor behind his nightstand. Resident #46 asked surveyor to hand the call light to him and he pushed it. The call light was not working. He said he thought they had turned the call light off and he had to holler out or pound on his bedside table to get help from someone since he moved to his current room after being in isolation on the Covid unit. During an observation and interview on 8/03/22 at 5:11 PM with CNA BB, she said when something was not working, she would write it the maintenance logbook and tell the charge nurse. She said Resident #46 either pushes his call light or hollers out for help. She said she was not aware Resident #46's call light was not working. She went into Resident #46's room and pushed both call lights that were on the floor behind the nightstand and she said they were not working. She said she would get someone to fix them. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record Review of a face sheet dated 8/2/22 revealed Resident #20 was an [AGE] year-old female, that admitted to the facility 11/14/18 with the diagnoses of heart failure, Alzheimer's disease (progressive disease that destroys memory and other important mental functions), weakness, lack of coordination, depression, high blood pressure, diabetes (blood sugar disorder), dementia (forgetfulness), history of a heart attack, and history of a stroke. Record review of the quarterly MDS dated [DATE] indicated Resident #20 was unable to complete the BIMS. Resident required limited to extensive assistance of one person for most ADLs. During an observation and interview on 5/02/22 at 10:50 AM with a family member of Resident #20, revealed the resident's call light was laid across her nightstand beside her bed. The resident's family member pushed the call light to see if it worked and the call light did not light up on the wall, light outside the room did not light up, and the call light alarm was not sounding. The resident's family member then pushed the second call light in the room that was hanging on the wall and the light on the wall was on, but the light outside the door did not light up and there was no call light alarm sounding. She said Resident #20 should have a working call light to be able to call for assistance when she needed it and not have to holler out for help. 3. Record review of a face sheet revealed Resident #43 was a [AGE] year-old female that admitted to the facility on [DATE] with the diagnosis of heart failure (when the heart muscle doesn't pump blood as well as it should), fracture vertebrae (occur when the bony block or vertebral body in the spine collapses), and osteoporosis (causes bones to become weak and brittle). Record review of a MDS dated [DATE] indicated Resident #43 was understood and understands others. The MDS indicated Resident #43 has a BIMS of 06 which indicated a moderate memory impairment. Resident #43 required limited assistance with most ADLs. Record review of a care plan dated 6/8/2022 revealed Resident #43 was limited in her ability to walk in the corridor related to having unsteady gait. Resident #43 was also noted to be a fall risk related to unsteady gait. During an observation on 8/1/2022 at 10:12 am, there was noted to be no call light plugged into the port on Resident #43's side of the room. A small plug was noted to be in the port with no cord or button attached to it. During an observation and interview on 8/2/2022 at 11:10am, the call light for Resident #43 was noted to have a small plug in the port with no cord and not button to press. Resident #43 stated she would just holler at her roommate to press the call light if they needed anything. Resident #43's roommate brought her call light over to Resident #43's side of the bed at this time. The roommate stated it was better for her to have the call light since they only had one because she was weaker. During an interview on 8/4/2022 at 5:40PM the DON stated she was unaware that Resident #43 and her roommate were sharing a call light. She was unaware how often the maintenance man was required to check call lights and could provide no information about the last time it had been done. 4. Record review of the face sheet dated 8/4/22 revealed Resident #10 was [AGE] years old, male, and admitted on [DATE] with diagnoses including muscle wasting and atrophy (is the decrease in size and wasting of muscle tissue), and quadriplegia (paralysis of all four limbs). (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS dated [DATE] revealed Resident #10 was understood and understood others. The MDS revealed Resident #10 had adequate vision. The MDS revealed Resident #10 had a BIMS of 14 which indicated intact cognition and required extensive assistance for dressing, bed mobility, and transfers. And required total dependence for toilet use, personal hygiene, and bathing. Record review of the care plan dated 7/13/22 revealed Resident #10 was at risk for fall related to impaired mobility and medication. Intervention included always keep call light in reach. The care plan revealed Resident #10 had self-care deficit related to quadriplegia as evidence by required assistance with ADLs. Interventions included total assistance x2 for bathing/showering, extensive assistance x 1-2 persons with bed mobility, and total assist x2 persons with lift for transfers. 5. Record review of the face sheet dated 8/4/22 revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis (is a disease that impacts the brain, spinal cord, and optic nerves, which make up the central nervous system and controls everything we do), need assistance with personal care, and muscle wasting and atrophy (shortening). Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance to total dependence for ADLs. Record review of the undated care plan revealed Resident #49 was a fall, safety, elopement risk with interventions of encourage use of call light and keep call light within reach. During an observation and interview on 8/1/22 at 10:30 a.m., Resident #49 was in bed with his call light on the floor. Resident #49 said he did not know where his call light was but even if he had it, staff do not answer it. He said if he needed assistance then he must holler out but he said his voice was not that loud so he could not be heard. Resident #10, Resident #49's roommate, said our call lights do not work half the time anyways. Resident #10 said look at the call light box, the red cancel button was lit. Resident #49 said the call light had been broken for about a month and maintenance had worked on it before. This surveyor noticed a red light on the call light panel box, but the call light was not going off in the hall. This surveyor walked outside of the resident's room and the hall light, to let staff know which room needed assistance, was not on. This surveyor went back into Resident #49 and Resident #10's room and pulled both call light cords out of the call light panel, no alarms went off, no staff arrived, and the red cancel button light remained lit on the panel box. During an interview on 8/2/22 at 8:15 a.m., the housekeeping supervisor said he had been helping with maintenance issues for about a month. He said Resident #49's call light wires could not get power and his call light button wasn't working either. He said after fixing the panel box and getting him a new call light cord, he also noticed the light bulb was out in the hallway. He said he did not know how long Resident #49's call light was not working but Resident #49 told him he pulled the cord on 7/31/22, evening trying to get it closer to him. He said the current maintenance man, had replaced the panel box about a month ago. He said staff verbally tell him about issues and put problems in a maintenance logbook. He said LVN C told him this morning, the light for Resident #10 and #49's room was going off at the nurse's station, but the resident's light was not on in the hallway. On 8/2/22 at 8:30 a.m. this surveyor went to look for the maintenance logbook on the back hall, at the nurse's station. The logbook could not be found by the CMA EE or LVN C. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/2/22 at 8:35 a.m., this surveyor asked the Administrator about the previously requested maintenance log that was online and the logbooks. She said she still had not been able to get ahold of the maintenance man to get the online maintenance log and the logbooks should be on the back hall. She asked the housekeeping supervisor to go look for it. It was never brought not provided prior to exit to this surveyor. During an interview on 8/4/22 at 5:40 p.m., the DON said call lights not being answered, in reach, or non-functioning could cause more falls. The DON said it is maintenance's responsibility to check call lights as part of their weekly and monthly facility audits. The DON said it was never reported there was missing or non-working call lights in any room in the facility. She said anyone that enters the room to provide care for the residents, is responsible for the call light being in reach. She said residents having to wait for long period of time to get changed could cause skin issues. She said it could make the resident feel sad because they may not feel important or seen. During an interview on 8/4/2022 at 6:30PM the Administrator revealed she was unaware of any nonfunctioning call lights in the building at this time. The Administrator stated not having a call light can increase the resident's risk for falling, injury, and increase the time they remain wet or dirty. This in turn could lead to skin breakdown and feelings of sadness and isolation. During a phone interview on 8/4/22 at 7:54 p.m., the Maintenance man said he had replaced Resident #10 and #49's call light panel box the last time it malfunctioned. He said he had worked on their call light system twice. He said the last time he fixed it was less than a month ago. He said he did not keep a paper log of maintenance issues. He said once a month in T.A.I.L.S (company required maintenance system), he checked random resident's call lights and light bulbs outside the door. Record review of a signed in-service for all staff dated 3/2/2022 given by RN M stated, calls lights must always be in reach and in working order for all residents. Record review of a facility answering the call light dated March 2021 revealed .be sure that the call light is plugged in and functioning at all times .report all defective call lights to the nurse supervisor promptly . Record review of a facility maintenance service policy dated November 2021 revealed maintenance service shall be provided .and equipment in safe and operable manner at all times .functions of maintenance personnel included .maintaining paging system in good working order .providing routinely scheduled maintenance service to all areas .the maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure .equipment are maintained in a safe and operable manner .the maintenance director is responsible for maintaining the following records/reports .work order request . maintenance schedules .