STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41392 Based on observation, interview, and record review, the facility failed to maintain a safe, comfortable, and homelike environment for 4 residents of 20 residents (Resident #10, #49, #19 and #7), reviewed for environment, in that: The facility failed to maintain an ambient air temperature range of 71 degrees to 81 degrees Fahrenheit in the 300 hallway, the dining room and in resident rooms. The failure could place residents at risk of loss of body heat and of a decrease in quality of life. Findings included: Resident #10 Record review of Resident #10's Admission Record revealed a [AGE] year-old-male admitted on [DATE] and originally admitted on [DATE]. His diagnoses included: stroke, muscle weakness, bipolar disorder, thyroid disorder, hypertension, obesity, psychosis, manic episode, mood disorder, paralysis of limbs, nerve damage, edema, diabetes, GERD and BPH. Record review of Resident #10's annual MDS dated [DATE] revealed a BIMS score of 15 indicating he was cognitively intact. He required extensive assistance of one person assist for most ADLs. He required only set up help for eating. He used a wheelchair for mobility. He was always incontinent of bowel and bladder. Resident #49 Record review of Resident #49's Admission Record revealed a [AGE] year-old-male admitted on [DATE] and initially admitted on [DATE]. His diagnoses included: brain bleed, nutritional deficiencies, mood disorder, hepatitis B, major depressive disorder, epilepsy, hypertension, pressure ulcer of the sacral region and colostomy status. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #49's annual MDS dated [DATE] revealed a BIMS score of 9 out of 15 indicating moderate cognitive impairment. He required extensive assistance with one person physical assist dressing and toilet use. He required limited assistance with one person physical assist for bed mobility and personal hygiene. He required supervision for transfers. He was always incontinent of urine and had a colostomy for his bowels. He used a wheelchair for mobility. Resident #19 Record review of Resident #19's Admission Record revealed a [AGE] year-old-male admitted on [DATE]. His diagnoses included: stroke, paralysis affecting one side of the body, hypertension, major depressive disorder, GERD and BPH. Record review of Resident #19's annual MDS dated [DATE] revealed a BIMS score of 15 indicating he was cognitively intact. He required supervision with one person physical assistance for all ADLs. He was always continent of bowel and bladder. He used a wheelchair for mobility. Resident #7 Record review of Resident #7's Admission Record revealed a [AGE] year-old male admitted on [DATE] and originally admitted on [DATE]. His diagnoses included: paralysis of the lower body, amputation of the right leg, hypertension, chronic pain syndrome, muscle contractures, paranoid schizophrenia and major depressive disorder. Record review of Resident #7's annual MDS dated [DATE] revealed a BIMS score of 14 out of 15 indicating he was cognitively intact. He required extensive two person assistance for bed mobility, transfers and dressing. He required extensive one person assistance for personal hygiene. He required total dependence of two person assistance for toilet use. He was always incontinent of bowel and bladder. He used a wheelchair for mobility. In an observation and interview on 12/13/2022 at 7:15 AM, Resident #49 came out of his room and was self-propelling in his wheelchair in the 300 hallway. He stated he was not getting any sleep because it was so cold in his room and that it was also cold in the hallway. He was wearing a long sleeve sweater and long pants. He stated he had told the nurses about being cold. He did not mention names. In an observation and interview on 12/13/2022 at 1:58 PM, Resident #19 was in his room. He was laying in the bed. He was wearing a long sleeve sweater, long pants and a thick blanket partially covering his lower body. He had stockings on his feet. He stated that there had not been heat in the 300 wing for 3 years now and it gets very cold. He stated from the nurse station on down the hall, it was cold. He stated during the freeze last time, it was very cold. He stated he had made complaints to the staff. He did not mention names. During an observation on 12/14/2022 at 8:00 AM, the air was very cold in the 300 hallway from the nurse station to the end of the hall where rooms [ROOM NUMBERS] were located. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 12/14/2022 at 8:20 AM, the Maintenance Director checked the air temperature with an infrared temperature sensor. The air in 300 hallway and rooms [ROOM NUMBERS] were very cold. The temperature sensor read 64 degrees Fahrenheit in the hallway outside of rooms 318, 320 and 321. room [ROOM NUMBER] was 59 degrees Fahrenheit. room [ROOM NUMBER] was 67 degrees Fahrenheit and the double hung window was open by approximately 4 inches. room [ROOM NUMBER] shared a wall with room [ROOM NUMBER]. room [ROOM NUMBER] was not checked for ambient air temperature. Resident #19, said he liked the fresh air, and this was why he opened the window. Resident #7's bed was by the window. Resident #7 was lying in bed with multiple layers of blankets and thick comforter covering his body from the neck on down. Resident #7 stated it was cold but was ok as long as he had lots of covers. Resident #10 stated it was colder than hell at night and that he would like it if the temperature was normal. Resident #10, stated he had told the staff. He did not mention any staff names. Resident #10 had multiple layers of blankets and a thick comforter. The Maintenance Director stated he did not know what the temperature of the rooms should be but was going to find out why it was cold. The Maintenance Director stated he had never received any complaints about temperature and that he started working at the facility three weeks ago. In an observation and interview on 12/15/2022 at 10:00 AM while walking through the dining room with LPN Z, it was cold and drafty in the dining room. LPN Z stated that the building had always been like this, hot in the summer and cold in other areas during other times of the year. LPN Z stated she would give a resident extra blankets if they complained of feeling cold. In an observation and interview on 12/14/2022 at 12:25 PM the Maintenance Director measured the air temperature of the dining room and the sensor read 66 degrees. The thermostat on the wall read 66 degrees. The Maintenance Director looked at the switch on the thermostat and stated someone put the air on, that was why it was cold. In an interview on 12/15/2022 at 7:15 AM, the Administrator stated she did not know what the facility temperature should be and referred this surveyor to ask the Maintenance Director. In an interview on 12/15/2022 at 10:50 AM, the Maintenance Director stated he thought the temperature in the building should be about 71 degrees to keep the residents comfortable. The Maintenance Director stated his assistant was supposed to monitor the temperatures and log the results. Record review of the facility's log for weekly room temperature checks revealed on 12/14/2022, the temperatures in rooms [ROOM NUMBERS] were 72 degrees Fahrenheit. room [ROOM NUMBER] was not listed as being checked. There were no times listed on the log. The log indicated there were no complaints received between 09/13/2022 and 12/15/2022. In an interview on 12/15/2022 at 4:40 PM the Maintenance Assistant was asked what time did he check temperatures in rooms [ROOM NUMBERS] on 12/14/2022, he stated at 8:00 AM. He stated when he checked temperatures he would choose random resident rooms and that was why not all rooms were listed as being checked. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/16/2022 at 9:25 AM, the Maintenance Director was asked how the temperatures documented on 12/14/2022 for rooms [ROOM NUMBERS] were different than what was measured with the infrared temperature sensor on 12/14/2022 at 8:20 AM. The Maintenance Director stated the Assistant could not have been in the building at 8:00 AM because he started work at 8:30 AM. The Maintenance Director stated he had already corrected the thermostat in 300 Hall by 8:30 AM on 12/14/2022 and the Assistant would then have checked temperatures afterwards. In an interview on 12/16/2022 at 9:59 AM, the DON stated she would have to ask Environmental Services about what safe building temperatures should be. The DON stated the temperature would also depend on the resident. Record review of the facility's policy and procedure titled Safe and Homelike Environment, copyright date 2022 read in part: .In accordance with resident's rights, the facility will provide safe, clean, comfortable and homelike environment, .Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia/ hyperthermia and is comfortable for the residents The facility will maintain comfortable and safe temperature levels .the facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit .if and when a resident prefers his or her room temperature be kept below 71 degrees Fahrenheit, or above 81 degrees Fahrenheit, the facility will assess the safety of this practice on the resident and the resident's roommate.

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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** 45604 Based on observation, interview, and record review the facility failed to accurately assess each resident's status for 1 of 17 Residents (Resident #24) reviewed for assessment accuracy in that: -Resident #24's Quarterly MDS dated [DATE] did not accurately assess his absence of natural teeth. -This failure could affect residents at the facility who had been assessed and place them at risk of not receiving the proper care and services due to inaccurate assessments. Findings Include: Resident #24 Record review of Resident #24's face sheet revealed he was a [AGE] years old male admitted to the facility on [DATE] with diagnoses that included Peripheral Vascular Disease(slow and progressive circulation disorder), Chronic Obstructive Pulmonary Disease(inflammatory lung disease), Cerebral Infarction(ischemic stroke), Hypercholesterolemia (high cholesterol), Hypothyroidism, Hypertension(high blood pressure), Unspecified Atrial Flutter(heart rhythm disorder), Hemiplegia (lack of control in one side of the body), Acquired Absence of Left Leg Below Knee, and Contracture of Muscle. Record review of order summary report with date range of 10/19/2022-12/31/2022 indicated a treatment order that read in part . Consult: May be seen and treated by a Dentist, with order date of 10/20/2022. Record review of Resident #24's quarterly MDS assessment dated [DATE] revealed Section C0500 (BIMS Summary Score) was triggered as 13, which indicated that resident was cognitively intact. Record review of Section L200 (Oral/Dental Status) of the MDS revealed that Section B (No natural teeth or tooth fragments) or Section A (broken or loosely fitting full or partial denture) were not triggered for Resident #24. Record review of Resident #24's care plan dated 11/17/2022 revealed that resident was not care planned for an Oral/Dental Status. In an interview and observation on 12/13/2022 at 8:15am with Resident#24, he stated that he requested to see a dentist because he needed dentures. He stated that he was on a puree diet, and he hoped that with dentures his diet would be changed to regular. He stated that he told the social worker that he wanted to see the dentist in November of 2022, he had a dental appointment scheduled, and the appointment was rescheduled for 12/19/2022. Observation of Resident #24 was made, and he did not have any natural teeth when he opened his mouth. He stated that he had dentures but there were teeth missing and he wanted a new set of dentures. Observation was made of resident's dentures to have multiple teeth missing at the top and there were no missing teeth on the bottom. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/15/2022 at 1:12pm with the Social Worker, she stated that Resident #24 does not have natural teeth or dentures. She stated that Resident #24 requested to see the dentist in November of 2022 for dentures. She stated that the facility has a contracted dentist that comes to the facility to treat residents. She stated that Resident #24 was on the schedule for 11/21/2022 but the dentist cancelled, and the appointment was rescheduled for 12/19/2022. She stated that she provide an email confirmation that the appointment was scheduled. In an interview and observation on 12/15/2022 at 1:20pm with Resident#24 while he was sitting outside of the facility with LVN H supervising. Resident#12 told the Social Worker that he had a set of dentures in his room that had missing teeth on the top. He stated that he could not remember being asked if he had dentures by staff. In an interview on 12/15/2022 at 1:25pm with LVN H, she stated Resident#24 does not have natural teeth and she was not aware of the resident to have dentures in his room. Record review of email thread dated 12/15/2022 at 1:43pm between Social Worker and dental office confirmed that Resident #24 was scheduled to be seen on 12/19/2022. In an interview on 12/16/2022 at 11:45am with the MDS Coordinator. She stated that she has been a MDS Coordinator since February of 2022. She stated that she uses the RAI manual as guidance in completed the assessments. She stated that she completed the MDS assessments for Resident #24 which included an interview with the resident and physical assessment. She stated that the resident does not have natural teeth. She stated that during an interview Resident #12 did not disclose that he had dentures. She reviewed the Quarterly MDS dated [DATE]. She stated that Section L200 Section B should have been triggered for Resident #24. She stated it was an oversite by her that it was not triggered and since she had not the residents dental care was not care planned. She stated, that is why I do not like to complete Section L and it should be completed by dietary. In an interview on 12/16/2022 at 11:58am with the Corporate Nurse and acting DON, she stated that she had no experience with MDS, or what policy/procedure the MDS Coordinator would have used to ensure that assessments are completed accurately. She stated that she did not what the RAI Manual was or what it was used for. She stated that she was familiar with Resident #24, but she did not know if he had natural teeth. She stated that she would agree with the MDS Coordinator if she stated that it was an oversite that Resident #24 was not triggered for have no natural teeth on the MDS. She stated that the oversite for the MDS Coordinator would be the nurse that signed the MDS. In an interview on 12/16/2022 at 12:08pm with Administrator, she stated that the RN that signed the MDS assessment was not signing for accuracy, but they are signing for completion. She stated that the oversite for the MDS Coordinator would be the DON. She stated that she was familiar with Resident #24, the resident did not have teeth, it should have been triggered on the MDS, and care planned. She stated that if the MDS did indicated that Resident #24 had no natural teeth it was an oversite by the MDS Coordinator. She stated that Resident #24 expressed that he wanted to see the dentist for dentures, and he was placed on the schedule to see the dentist. She stated that the facility does not have a written policy for accuracy of assessments, and the facility utilizes the RAI manual for completing the MDS. (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 written statement completed by the Administrator and dated 12/16/2022 read in part, .[This facility] does not utilize a separate policy regarding facility MDS accuracy, the facility follows the recommendation of the RAI manual. Record review of the CMS RAI Version 3.0 Manual for the MDS Assessments dated October 2019 read in part, .Section L: Oral/Dental Status Intent: This item is intended to record any dental problems present in the 7-day look-back period. Planning for Care: Assessing dental status can help identify residents who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes. 4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth. Coding Instructions: Check L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk. Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on interview and record review, the facility failed to ensure they coordinated with the appropriate, State-designated authority, to ensure that individuals with a newly diagnosed mental disorder received care and services in the most integrated setting appropriate to their needs for 1 (Resident #10) of 2 residents reviewed for PASSR. The facility failed to complete and submit an accurate PASRR Level 1 for Resident #10 when he was newly diagnosed with a mental illness. This failure could place residents who had a positive PASRR Level 1 or residents with a diagnosis of mental illness at risk for not receiving care and services to meet their needs. Findings included: Record review of Resident #10's Admission Record revealed a [AGE] year-old-male admitted on [DATE] and originally admitted on [DATE]. Record review of Resident #10's PASRR Level 1 Screening dated 01/14/2020 completed by the facility revealed Section C was answered No for mental illness, intellectual disability and developmental disability. Record review of Resident #10's Admission Record included the following diagnoses and onset dates: bipolar disorder(11/06/2020), manic episode(03/01/2017), psychosis (03/01/2017) mood disorder(03/01/2017), stroke(03/15/2019) and muscle weakness(04/01/2021). There was no diagnosis of dementia. Record review of Resident #10's annual MDS dated [DATE] revealed a BIMS score of 15 indicating he was cognitively intact. Section E of the MDS revealed the resident was coded for verbal behavioral symptoms directed toward others. Section N of the MDs revealed the resident received antidepressants during the last 7 days. Record review of Resident #10's active physician orders dated revealed the following orders: *Divalproex Sodium 125 mg, 2 capsules for psychosis with the order date 03/31/2022. *observations for side effects of antidepressant medications with the order date 08/09/2022. Record review of Resident #10's care plan last reviewed on date 11/03/2022, revealed he used antidepressant medications r/t Bipolar Disorder, date initiated and revised on 07/08/2022. Interventions included to give antidepressant medications ordered by the physician. Monitor/document side effects. The resident had impaired cognitive function or impaired thought processes r/t Psychosis, AEB BIMS = 10, date initiated and revised on 09/13/2018. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #10's Form 3713: Consent for Antipsychotic or Neuroleptic Medication Treatment dated and signed on 3/30/2022 by the Nurse Practitioner and Physician, revealed the prescribing physician had been treating Resident #10 since 05/29/2021. Further review revealed the resident was believed to have the following psychiatric condition and/or maladaptive behavior: F 25.0 and that the diagnosis was based on the following dominant characteristics exhibited by the resident: diagnoses of psychoses, manic depression, psychiatric hospitalization in late teens followed up by psychiatrists and types of medication prescribed by psychiatrist such as Depakote and Geodon. Record review of Resident #10's Form 1012: Mental Illness/Dementia Resident Review, revealed the form was incomplete. The Form 1012 was completed on 12/14/2022, during survey, marking it as complete 23 months after the diagnosis of bipolar disorder and 9 months after the physician wrote the resident was hospitalized for psychiatric diagnoses in his late teen years. In an interview on 12/15/2022 at 7:21 AM, the MDS Nurse stated Resident #10 had symptoms that began probably from dementia when he had a stroke in 2014. The MDS Nurse stated she just submitted in the Simple portal for the PASRR evaluation. The MDS Nurse stated the resident had not been hospitalized for psychiatric issues and knew that this would be one of the questions that would be asked. MDS Nurse stated Resident #10 will probably not be confirmed as having MI, ID, or DD. In an interview on 12/15/2022 at 3:55 PM, the MDS Nurse stated she did not see a note from the doctor, then checked again and saw the consent letter for Resident #10. When asked what prompted her to file the form 1012, she stated that it was the diagnosis of Bipolar disorder. She stated if she received that letter, she would have filed the 1012 right away. She stated it was the responsibility of the other MDS Nurse who was in charge of Medicaid residents and that nurse no longer worked at the facility. In an interview on 12/16/2022 at 9:59 AM, the DON stated that she did not know about PASRR screening and that was the responsibility of the MDS Nurse or SW. The DON stated if they needed a nurse she would then be involved. Record review of the facility policy and procedure, not dated, titled Resident Assessment - Coordination with PASARR Program read in part: .This facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs .9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include .b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604 47215 Based on observation, 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, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #38) of 20 residents reviewed for care plan in that: The facility failed to develop an individualized care plan for activities for Resident #38. This failure could place residents at risk of a diminished quality of life leading to a variety of emotional and physical problems/issues. Findings included: Record review of resident #38's face sheet revealed a [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE]. Her diagnosis was dementia (a condition characterized by progressive or persistent loss of intellectual functioning), behavioral disturbances, and mood disorders with major depression (depression is a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of resident #38's Comprehensive MDS dated [DATE] revealed resident #38 had a BIMs score of 05 indicating the resident was severely cognitively impaired. The resident required extensive assistance with two persons physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene. The resident required supervision with setup help for eating. The MDS Preferences for Customary Routine and Activities, section noted listening to music was very important to resident #38. Her least interest was noted as books, newspapers, and magazines. Record Review of resident #38's activity's monitoring sheet titled, assistant face to face form, not dated, read in part .11/15/22: 5 minutes of reading and conversation; 11/17/22: 5 minutes of conversation and snack time; 11/19/22: 5 minutes of Reading; 11/22/22: 5 minutes of conversation; 11/24/22: No activity documented; 11/26/22: conversation; 11/29/22 5 minutes of conversation; 12/01/22: 5 minutes of conversation; 12/3/22: 5 minutes of conversation; 12/6/22: Time not indicated, conversation and feeding; 12/8/22: 5 minutes of conversation; 12/10/22: 5 minutes of conversation, and 12/13/22: 5 minutes of conversation . Record Review of resident #38's care plan dated 11/03/2022 revealed resident #38 was not care planned for activities. Observation and Interview on 12/14/2022 at 1:08 pm with resident #38 revealed was dressed and well-groomed. Resident #38 had no understanding. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/14/2022 at 1:20 pm with CNA A, she said resident #38 did come out of her room to participate in activities. She said the last time resident #38 participated in activities was on 11/10/2022 for arts, crafts, movies, and popcorn. She said before 11/10/2022, resident #38 participated on 9/27/2022. She said certain staff would encourage resident #38 to participate in activities. Observation on 12/15/2022 at 3:00 pm revealed resident #38 sleeping in bed, lying on her back with the sheet pulled up to her neck. Observation on 12/15/2022 at 3:05 pm revealed residents participating in activities with the Assistant Director of activities. Further observation revealed the residents finished the bingo activity. Resident #38 was not in attendance. In an interview on 12/14/2022 at 4:11 pm with the Administrator, she said she has only been in her position for two weeks. She said looked at resident #38's care plan and verified that resident #38 was not care planned for activities. She said all residents should be care planned for activities. She could not say why the failure to care plan resident #38 for activities occurred because she had only been at the facility for two weeks. She said she hired a new activity director who would start on the 27th of December. She said she would ask her to come into the facility this weekend to discuss activities and care plans. She said the last activity's director resigned before she started her position. She said nurses were responsible for developing and revising care plans. Record review of the facility's policy titled Activities revised on 11/17 read in part . it is the policy of this facility to provide an ongoing program to support residents in their choice based on comprehensive assessment, care plan, and preferences. Activities be encouraged within the community. 8. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. The facility will consider accommodations in schedules, supplies, and timing to optimize a resident's ability to participate in an activity of choice. The physician, in coordination with the comprehensive assessment, approves activity programs . Record review of the facility's policy titled Comprehensive Care Plans, dated 2022, revealed it is the policy of this facility to develop and implement a comprehensive person-ecntered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on observation, interview and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrated that it was not possible, or the resident's preferences indicated otherwise for one of six residents (Resident #36) reviewed for weight loss and nutrition. The facility failed to identify early, assess and modify interventions consistent with Resident #36's significant weight loss on 12/06/2022. The facility failed to notify the physician as appropriate in evaluating and managing Resident #36's significant weight loss on 12/06/2022. These failures could place the residents at risk of health complication related to nutritional and hydration. Findings included: Record review of Resident #36's Admission Record revealed a [AGE] year-old female admitted on [DATE] and originally admitted on [DATE]. Her diagnoses included: difficulty swallowing, diabetes, unstageable pressure ulcer to the sacrum, pneumonia, urinary tract infection, hypertension, muscle wasting, acute kidney failure, acute liver failure, encephalopathy (brain disorder), fluid in the lungs, irregular heartbeat, shingles, and urine retention. Further review of the Admission Record revealed Anasarca (generalized edema) was not listed as one of the diagnoses. Record review of Resident #36's Admission MDS dated [DATE] revealed the resident had adequate hearing, had no speech, rarely/never made herself understood, rarely/never understood others and had impaired vision. The resident was totally dependent on one to two staff assistance for all ADLs. The resident had an indwelling urinary catheter and was always incontinent of bowel. Section K of the MDS revealed a weight of 132 lbs., and a height of 69 inches. The resident had a feeding tube both while not a resident and while a resident at the facility. Further review of the MDS revealed Anasarca was not listed in Section 1, Active Diagnoses. Record review of Resident #36's electronic care plan, date initiated 10/15/2022 and revised on 12/13/2022, revealed the resident required tube feeding due to Dysphagia (difficulty swallowing). The goals were for the resident to maintain adequate nutritional and hydration status AEB weight stable, no s/sx of malnutrition or dehydration. Interventions were for the RD to evaluate quarterly and PRN, Monitor caloric intake, estimate needs, and make recommendations for changes to tube feeding as needed, date initiated on 10/15/2022. Further review of the care plan revealed there was no plan for potential weight loss r/t diuretic use or Anasarca. Record review of Resident #36's active physician orders as of 12/16/2022 revealed the following orders: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	*continuous enteral feeding formula Isosource 1.5 at a rate of 50cc/hour x 22 hours and every shift water to be set at 30cc/hour to run concurrently with enteral feeding. *Furosemide 20mg tablet to be given enterally two times a day to be given as a diuretic, order date 10/29/2022; *Multiple Vitamins-Minerals 5 ml in the morning for supplement, order date 11/02/2022, *Vitamin C 5ml in the morning for supplement, order date 11/02/2022 and *Zinc 220mg once a day for wound healing, order date 11/02/2022. Record review of Resident #36's October 2022 and November 2022 MAR revealed the following: *10/14/2022 through 10/25/2022, the resident was receiving enteral feeding of Nepro 1.8 at a rate of 50ml/hour. *10/30/2022 through 11/06/2022 the resident was receiving Peptamen 1.5 at 30ml/hour and water at 50ml/hour. Record review of Resident #36's October 2022 MAR revealed an order in October for weekly weights x 4 weeks from admission every Monday then monthly weights. There were no documented weights except on 10/31/2022. Record review of Resident #36's November 2022 MAR there were no documented weights except on 11/28/2022. Record review of Resident #36's December 2022 MAR did not have an order for weights. Record review of Resident #36's November 2022 and December 2022 MAR revealed on 11/07/2022 through 12/15/2022, the resident was receiving enteral feeding of Isosource 1.5 at a rate of 30ml/hour and 50ml/hour of water. Further review of the MAR revealed a new order for Isosource 1.5 at 50ml/hour was started on 12/15/2022. Record review of Resident #36's hospital records dated 10/10/2022 revealed on 10/14/2022 her weight was 123.2 lbs., and height was 62.5 inches. On 10/26/2022 her weight was 120 lbs., and her height was 62 inches. Further review of the resident's hospital records revealed a diagnosis to include Anasarca. Record review of Resident #36's weight log from October 2022 to December 2022 revealed the following: *12/15/2022 at 9:02 AM, 97 lbs. (Mechanical Lift), recorded by Unit Manager A,-7.5% change (comparison Weight 10/31/2022, 119.0 lbs., -18.5%, -22lbs) *12/06/2022 at 4:17PM (no device was listed), 97.8 lbs., recorded by Corporate Nurse, -7.5% change (Comparison weight 10/31/2022, 119.0 lbs., -17.8%, -21.2 lbs.) *11/28/2022 at 9:35 AM, 119 lbs. (Mechanical Lift) *11/01/2022 at 11:20 AM, 119 lbs. (Mechanical Lift) *10/31/2022 at 1:39 PM, 119 lbs. (Mechanical Lift) *10/31/2022 at 1:38 PM, 119 lbs. (Mechanical Lift) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Further review revealed there was no recorded admission weight on 10/14/2022 or a weekly weight prior to hospital discharge on 10/25/2022. There was no recorded readmission weight on 10/29/2022. Record review of Resident #36's Dietician Comprehensive assessment dated [DATE] 12:55PM written by the RD, read in part: . Physical Information .Ideal Body Weight 130-160#, percent of ideal body weight 83% . Plan/Recommendations/Additional Comments - [AGE] year-old female admitted with dx of dysphagia. Wt. 132.4# Ht. 69 in. BMI= 19.5 diet - NPO receiving enteral feeding - Nepro 1.8 @ 50 ml.hr x 22 hours, off 5-7pm provides 1100 ml., 1980 kcal's, 89.1 grams protein, 799.7 ml free water, water flushes 50 ml flush every 4 hours + 30 ml before and after each medication., tolerating TF well current TF meeting calorie needs. Receiving Furosemide-there is an expected weight change. PES = increased calorie and protein needs r/t healing process AEB unstageable pressure ulcer to sacrum Observation on 12/13/2022 at 8:04 AM, resident #36 was in bed laying on her left side with a wedge under her back. The HOB was raised. Tube feeding of Isosource 1.5 was infusing continuously at 30ml/hour and water at 50ml/hour. The resident had a tracheostomy connected to the ventilator. The resident's eyes were closed, and she did not respond to verbal greeting. The resident's lips were dry, her face thin with sagging facial skin. Her wrists and forearms were thin. Here limbs were severely contracted. In an interview on 12/15/2022 at 11:29 AM, RN G stated she had been working at the facility for a year and started working with Resident #36 when she was in the 100 hall. RN G stated that she believed the Restorative Aides perform the weekly weights for the resident. Typically, the restorative aide weighs and then tells the nurse what the weight was. The nurse would be responsible for checking the weight and if needed, would consult the RD. The dietician would come twice a week and if there was a weight change, the dietician would switch the feedings and nurses would make adjustments on the order. RN G stated she did not notice any physical changes with Resident #36. She recalled Resident #36 was sent to the hospital for critical lab results. The restorative aide would enter the weights into the system and everyone including the RD would be notified of changes. The nurses are responsible for checking trends in weights. Both nurses and restorative aides would see the weight trends. A weight gain or weight loss of 5 lbs. in one week would grab her attention and she would notify the RD, MD and family member. RN G stated she was unaware of any weight loss or known conditions causing fluid retention for Resident #36. RN G stated she made skilled nurse assessment notes on her residents at least every shift. She said someone was always assessing Resident #36 physically especially when skin assessments were done weekly and when working with the Gtube. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an interview on 12/15/22 at 12:42PM, Unit Manager A stated she did not work closely with Resident #36 or any resident unless there was a clinical issue and there was no issue brought to her attention regarding this resident. She stated she did not weigh residents, but the RNA gave her a weight sheet that she referred to update resident weights in the EHR. She stated she was aware of who was in charge of the weight program but just knew the DON typically addresses weights and the RD reviewed patients' weights. If there was a significant weight loss or change in condition, the DON and RD would be notified immediately, as well as the physician and responsible party. She stated she did not notice any weight loss in Resident #36 because the last weight she entered was 97 lbs. on 12/14/2022, whereas the previous weight entered on 12/06/2022 was 97.8lbs which was not significant weight drop between the two dates. She stated she did look further back at any additional weights prior to 12/06/2022 for resident #36 as to review her weight history. When asked if she notified any parties about the Resident's weight, she stated she talked to the NP and notified her of resident #36's weight being 97lbs as a matter of fact, but not that there was any recent weight loss. She defined a significant weight as 5% or more, the time frame of the weight loss was dependent on the patient and the implications of weight loss that goes unaddressed was dependent on patient and their diagnoses. In an interview on 12/15/2022 at 2:52 PM, RD stated she was instructed to come to the facility because the State had questions. She stated she just saw Resident #36's weight loss today, was not notified by nursing staff about her weight loss but picked up on it on her own and spoke with the DON and Administrator. She stated the DON provided information on weight loss on a monthly basis and residents would verbally report weight concerns to her. If there was no significant change, she would at least do a monthly assessment but every now and then she would look at the residents if they appear on the list. With readmissions, she would automatically see the residents for a reassessment. The RD stated that within a week of Resident #36's admission she would have been seen. She would either check the EHR system to see which of her residents were readmitted or she would ask the admissions staff. She stated she did not know how Resident #36 was not reassessed and that she just missed it. She stated no one alerted her after the weight loss indicated on 12/06/22. The RD stated Resident #36 was on Nepro 1.8 at 50m/hour prior to hospitalization . She had expected weight loss because the resident was on Lasix IV while in the hospital and was presently on Lasix 20mg BID. D stated with Lasix the weight would still fluctuate, even if on oral Lasix. RD stated the resident returned on 10/29/2022. Normally the restorative aide would give her a list of residents' weights. If a resident had a Gtube, usually they were weighed weekly. RD stated if weights seemed unusual, she would ask for a reweigh or would go by the most recent recorded weight. RD stated that based on Resident #36's new weight and corrected height, the minimum calories for her would be 1500 for weight gain and BMI of 18 or above would be the goal. When asked about the risks for Resident #36 if changes to her diet were not made, the RD stated the resident would continue to lose weight. RD stated she would have reassessed and increased the enteral feeding. RD stated usually the facility would notify her of any significant weight loss and usually the facility would then do weekly weights. RD stated she was at the facility twice a week and did not recall if she was at the facility between 11/28/2022 and 12/06/2022. RD stated she did not remember if it was the DON or if it was another nurse who made her aware of the weight loss. In an interview on 12/15/2022 at 3:08 PM, RD was asked about the Comprehensive Assessment she wrote on 10/20/2022 and where she got the weight of 132.4 lbs., she stated she got the weight from the Restorative Aide. She did not remember which Restorative Aide. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 12/16/2022 at 7:30 AM, a request was made to the Administrator for the Restorative Aide Weight Logbook and was requested again from the DON on 12/16/2022 at 12:15 PM. No Restorative Aide Weight Logbook was submitted by the time of exit. In an interview on 12/16/2022 at 7:38 AM, RA C stated she was not done with completing training by PT and once done she would be the lead Restorative Aide. RA C started in the Restorative aide role on 12/08/2022, prior to that she was in a CNA role. RA C stated she was trained by the previous Restorative Aide lead who was no longer employed at the facility. RA C stated if weights were off by 3 lbs., she would reweigh and compare to previous weights. RA C stated she had never weighed Resident #36. RA C stated she received training using the Hoyer lift (mechanical lift) when she started as a CNA and that all CNAs should know how to use the Hoyer lift. RA C stated she would give the weight results to the DON and the DON had the Restorative Aide Weight Logbook. RA C stated everyone was weighed on the first of the month including Gtube residents and residents losing weight. RA C stated that her understanding was that residents were to be weighed weekly. RA C stated that Gtube residents should always come up weekly. RA C stated the nurse and RD would review the residents first and then give the Restorative aide a list. RA C stated as soon as a resident was admitted , the resident was weighed even if the admission was late at night. The weighing should be as close to the admitted as possible. In an interview on 12/16/22 at 8:25 AM, the Administrator stated the RD was given an admission report from the nursing department for residents on enteral feeds. She was not aware of the weight change not being reported after Resident #36'sweight of 97.8 lbs. was documented on 12/06/22 by the Corporate Nurse. She stated that the weight change should have been reported immediately to the RD and the physician. In an interview on 12/16/2022 at 8:35 AM the MDS Nurse stated that she told the RD, face to face last week, that Resident #36 had a significant weight loss. She stated that RD told her ok and that she will see her next week. MDS Nurse stated she did not document the conversation but that she should have. MDS Nurse stated the RD was responsible for notifying the MD and RP of the significant change. MDS Nurse stated it would be Unit Manager A who knew about Resident #36's weight of 97 lbs. was entered on 12/15/2022. MDS Nurse stated she did not know who entered the weight of 97.8 lbs. on 12/06/2022. MDS Nurse stated the facility had a change in Restorative Aides and was unsure if the weights entered were correct because of this change. MDS Nurse stated she was not the MDS nurse when Resident #36 was admitted , it was another MDS nurse who was no longer employed at the facility and that her plan was to review all resident's weights. MDS Nurse stated Resident #36 had the diagnosis of Anasarca and that was found in the hospital records. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on 12/16/2022 at 9:08 AM, Corporate Nurse was at the facility for one week during November/December to help out. Corporate Nurse stated she vaguely remembered that Resident #36's weight had decreased but actually looked up her orders and her diagnoses. Corporate Nurse stated Resident #36 had muscle wasting secondary to a stroke, was on Lasix and also had Anasarca (generalized body swelling) which affects the entire body, and it could be dramatic. Corporate Nurse stated on the day she weighed Resident #36, she talked to the aides who said the resident did not look different and asked for a reweigh. Corporate Nurse stated she did not get the reweight as she had to catch a plane and she left the same day she believed. Corporate Nurse stated she spoke to a nurse in the unit but did not remember any names because she had never worked at this facility before. Corporate Nurse stated she did look at Resident #36's records and recalled the diagnosis and this was all that she remembered. Corporate Nurse was asked about Resident #36's weight loss of 20 lbs. Corporate Nurse stated that a reweigh should have been done and that was the biggest issue. Corporate Nurse stated she knew the practitioner was supposed to be coming and she would have been made aware of the resident's weight by the staff. Corporate Nurse stated all the communication was verbal. When asked what the implications were if information was not documented, RN K stated she did not know what Texas rules and requirements were and that she had a Missouri state compact license. RN K stated she realized everything should be documented in order to follow through with the resident's needs and for the NP to be made aware. Corporate Nurse stated she spoke to the staff and assumed they would follow through. Corporate Nurse stated she did not know what the policy and procedure for documentation was for the facility. In an interview on 12/16/2022 at 9:59 AM, the DON stated the MDS Nurse would run a report when there was a significant change in weight. The RD would be alerted, the RD would make recommendations and the NP would be notified. The DON stated, she did not know but the MDS nurse would be the one to know if an SBAR would be triggered by a significant weight loss. In an interview on 12/16/2022 at 10:50 AM, MDS Nurse stated that yes, a significant weight loss would trigger an SBAR, and that Unit Manager A was responsible for initiating and writing the SBAR. MDS nurse stated that the SBAR should be written now for Resident #36. In a telephone interview on 12/16/2022 at 1:48 PM, the NP stated that Resident #36 was one of her residents she saw twice a week. NP stated she was first notified of the significant weight loss yesterday, 12/15/2022. NP stated that she spoke with the consulting dietician (RD) on 12/15/2022 so the dietician could make recommendations. NP stated she would leave the decision making for the RD. NP stated that Resident #36 should be gaining more weight and not losing weight because she is bedbound and that she will be ordering a battery of labs today (12/16/2022). NP stated she was not exactly sure why the resident was losing weight and that the liver failure could be an issue for weight loss. NP stated Resident #36 is her resident and would always need to know what is going on with her. NP stated they may not be weighing the resident the same way all the time and should be weighing with the same clothes and at the same time of day. NP stated she expected that residents get weighed upon admission and then said maybe weekly thereafter. NP stated she did not look at all the data on the resident all the time when visiting but if the facility brought a change to her attention, then she would address it. When asked if she was aware of the 97.8 lb. weight on 12/06/2022, what would she have done for the resident. NP stated she would have ordered the labs and consulted with the RD exactly like she did when she found on 12/15/2022. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #36's Dietician Comprehensive assessment dated [DATE] 11:30 AM written by the RD, read in part: .Demographics/Background .4. current diet order: NPO .B. Physical Information 1b. Most Recent Weight 97 lbs., date: 12/15/2022 9:42 AM, .ideal body weight 99 - 121 #, percent of ideal body weight 80% .current height=62 in Medications .Furosemide tablet 20mg, 1 tablet, enterally, two times a day, Pantoprazole Sodium Packet 40 mg, 1 packet, enterally, every 12 hours .Laboratory Data .Pre-Albumin 21.0 . Plan/Recommendations/Additional Comments - Review of weight loss, current wt. 12/11 = 97#, current Ht = 62 in ., BMI = 17.7 underweight .previous weight 11/28 = 119#; 10/21 = 119# there is a weight loss of 18. 48%/22# x 30 days. There is an expected weight loss r/t liver disease and stroke. Resident was on Lasix 60 mg. IV with a BUN of 151 high in the hospital, currently the resident is on Lasix PO. There still an expected weight loss, recommend to increase enteral feeding Isosource 1.5 @50ml/hour x 22hours off from 5-7 pm with 30 ml water flush continuous, enteral feeding will provide 1100 ml, 1650 kcal's, 70.18 grams protein, 8386 ml free water/day, continuous 30 ml water flush before and after each medication administration, resident has a unstageable pressure ulcer to sacrum. Record review of Resident #36's progress notes from 12/06/2022 to 12/15/2022 revealed that the RD, NP, and RP were not notified of the significant weight loss after 12/06/2022 when the resident's weight was 97.8 lbs. or at any time prior to 12/15/2022 at 1:00 PM. Further review of the progress notes revealed the Dietician Comprehensive Assessments were not completed within 72 hours of admission, readmission or significant change of condition and the SBAR was not completed prior to 12/15/2022. Record review of the facility's policy and procedure titled Nutritional Management, dated 2022 read in part: Policy: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Definitions: Acceptable parameters of nutritional status refers to factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis, such as weight, food/fluid intake, and pertinent laboratory values .Compliance Guidelines: .2. Identification/assessment: a. Nursing staff shall obtain the resident's height and weight upon admission, and subsequently in accordance with facility policy .c. A comprehensive nutritional assessment will be completed by a dietician within 72 hours of admission, annually and upon significant change in condition. Follow-up assessments will be completed as needed. Components of the assessment may include, but are not limited to: i. General appearance, ii. Height/weight .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455815	A. Building B. Wing	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Rehabilitation and Care Center	10851 Crescent Moon Dr Houston, TX 77064

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43049 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 10 residents (Resident #1) and 4 of 4 medication storage areas (100 Hall Med Cart 1, 200 Hall Med Cart 1, 200 Hall Med Room, and 300 Hall Med Cart #2) reviewed for pharmacy services. - The facility failed to ensure the medication carts and med rooms did not include expired insulin for Resident #3, Resident #14, Resident #41, Resident #100 and Resident #105 - LVN D administered Heparin (a blood thinner) to Resident #1 that had no open date. These failures could place residents at risk of not receiving the therapeutic benefit of medications and/or adverse reactions to medications. Findings Included Resident #1 Record review of Resident #1's Face Sheet dated 09/06/22 revealed, a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: chronic respiratory failure, type 2 diabetes, seizures, hemiplegia and hemiparesis (muscle weakness and paralysis on one side of the body) , pressure ulcers, and hypertension. Record review of Resident #1's MDS dated ,d+[DATE] revealed, moderately impaired cognitive skills for daily decision making and total assistance with all ADLs. Record review of Resident #1's Care Plan dated 11/03/22 revealed, Focus- anticoagulant therapy; Intervention- monitor/report as needed adverse reaction of anticoagulant therapy. Record review of Resident #1's Physician's Orders dated 12/07/22 revealed, Heparin 5000 units/ml- 1 dose subcutaneously two times a day. An observation on 12/13/22 at 08:53 AM revealed, LVN D preparing medication for administration to Resident #1 via G-tube, she prepared the solid medications and poured 15 ml of Chlorohexidine 0.12% in individual cops and 1 ml of Heparin 5000 units/mL and entered into the resident's room. The bottle of Heparin was observed to have no open date. LVN D entered into the resident's room, administered the oral medications via G-tube and injected 1 ml of Heparin 5000 units/ml into Resident #1. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/13/22 at 11:34 AM, LVN D said all multidose vials must be labeled with date when opened in order to track the expiration date. She said the vial of Heparin used for administration to Resident #1 did not have an open date, so its expiration date could not be determined so she should not have used it. LVN D said since the vial of Heparin could not be used it should be discarded in the drug disposal bin located in the med room because use would place residents at risk of infection. 100 Hall Med Cart 1 An observation and interview on 12/13/22 at 8:13 AM, inventory of the 100 Hall Med Cart 1 with LVN D revealed: - 2 expired an in-use Insulin Lispro vials for Resident #14 with open dates with manufacturer's instructions to discard 28 days after opening with open dates of 09/27/22 and 10/28/22. LVN D said nursing staff are expected to check their carts daily as used for expired and inappropriately labeled medications. She said multi-dose medications should be labeled with the date once they are opened in order to track the expiration date. She said once insulin expires it can become less effective or contaminated so it can no longer be used. LVN D said expired insulin must be discarded in the drug disposal bin located in the med room. LVN D said that use of expired insulin and could place residents at risk of GI upset, infection and uncontrolled blood sugar. 200 Hall Med Cart 1 An observation and interview on 12/13/22 at 07:56 AM, inventory of the 200 Hall Med Cart 1 with LVN F revealed: - an open and in use Humalog Insulin pen for Resident #100 without an open date - an open and expired Insulin Glargine vial for Resident #100 with an open date of 11/12/22 and an auxiliary label that read Exp. Date 28 days LVN F said nursing staff are expected to check their carts daily as used for expired and inappropriately labeled medications. LVN F said after insulin expires it could lose potency or become contaminated and could place residents at risk for uncontrolled blood sugars and infection. 200 Hall Med Room An observation and interview on 12/13/22 at 07:46 AM, inventory of the 200 Hall Med Cart 1 with LVN F revealed: - an open and expired in-use bottle of Acetaminophen 500 mg with manufacturer's expiration date of 11/2022. - an expired bag of Vancomycin 1 g infusion (an antibiotic) with an expiration date of 11/25/22 in the fridge for Resident #105 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN F said she did not know who was responsible for checking the nursing carts for expired medications. She said that Resident #105 was no longer receiving the Vancomycin IV and since the medications were expired they must be discarded in the drug disposal bin because use would place residents at risk of adverse reactions. 300 Hall Med Cart #2 An observation and interview on 12/13/22 at 07:34 AM, inventory of the 300 Hall Medication Cart 2 with LVN E revealed: - an expired Humalog Insulin pen for Resident #3 with an open date of 10/28/22 and a label to discard after 28 days. - an expired Lantus Insulin pen for Resident #41 with an open date of 09/06/22 and a label to discard after 28 days LVN E said nursing staff are expected to check their carts daily as used for expired and inappropriately labeled insulin containers. She said when insulin expires it can become infection or contaminated so it must be discarded in the drug disposal bin in the med room because use could place residents at risk of adverse reactions. In an interview on 12/13/22 at 12:23 PM, the DON said nursing staff must check their carts daily for expired/inappropriately labeled medications and all nurses are responsible for checking the med rooms. She said all prescription medications should have a pharmacy label which included: drug name/strength/directions for use, patient identifiers and open dates in the case of insulin. The DON said that when insulin expires it can become less efficacious or contaminated, and all expired or inappropriately labeled medications should be discarded in the drug disposal bins located in the med rooms because their use could place residents at risk of inadequate therapy, medication errors or adverse reactions. used. Record review of the facility policy titled Multi-dose Vials without a revision date, 2- multi-dose vials will be re-labeled with a beyond use date, 28 days after the vial is opened or punctured (unless otherwise specified by the manufacturer).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 43049 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 9 percent based on 3 errors out of 31 opportunities, which involved 3 of 5 residents (Resident #1, Resident #2 and Resident #11); and 3 of 5 staff (LVN A, LVN B and LVN D) reviewed for medication errors. - LVN D failed to ensure medication administered to Resident #1 had a Physician's order. - LVN A failed to administer the correct eye drop to Resident #2. - LVN B failed to administer the correct multivitamin to Resident #11. These failures could place residents at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health. Findings included: Error #1 An observation on 12/13/22 at 08:53 AM revealed, LVN D preparing medication for administration to Resident #1 via G-tube, she prepared the solid medications and poured 15 ml of Chlorohexidine 0.12% in individual cops and entered into the resident's room. After administering the medications via G-tube to Resident #1, LVN D dipped 2 sponges into the cup containing Chlorohexidine and used them to wash the inside of the resident's mouth and teeth. Record review of Resident #1's Physician's Orders revealed, no active prescription for Chlorhexidine 0.12% (a mouth wash). A prescription for Chlorhexidine- give 15 ml via PEG-Tube in the morning for mouth wash use swab discontinued on 12/07/2022. In an interview on 12/13/22 at 11:46 AM, LVN D said that prior to administering medication nursing staff must verify the medication against the resident's orders and medications can only be administered with a Physician's order. She said that Resident #1 used to have an order for Chlorohexidine mouth wash and the medication was in her cart, so she instinctively administered the medication. LVN D said she did not realize Resident #1's mouth wash had been discontinued by the doctor. She said administration of medication without an order could place residents at risk of side effects. Error #2 An observation on 12/13/22 at 09:52 AM revealed, LVN A preparing for administration of medication to Resident #2. She retrieved a box of Artificial Tears Glycerin Solution with 0.2% Glycerin, 0.2% Hypromellose and 1 % Polyethylene Glycol 400 and 8 solid form medications and entered into the resident's room. After administering the 8 oral medications, LVN A placed 1 drop of the Glycerin eye drop in each of Resident #2's eyes. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's active Physicians Order's for 12/2022 revealed, Artificial Tears Solution 1% (carboxymethyl cellulose sodium) Instill 1 drop in both eyes two times a day for dry eyes. An attempt was made to interview LVN A on 12/13/22 at 11:00 AM, the staff member was not available. Error #3 An observation on 12/13/22 at 09:05 AM revealed, LVN B preparing medication for administration to Resident #11. She retrieved 1 tablet of Once Daily Multivitamins with Minerals as well 3 other solid medications, entered into Resident #11's rooms and administered the medications. Record review of Resident #11's Physician's Orders dated 03/01/22 revealed, Multivitamin Tablet- Give 1 tablet by mouth one time a day. In an interview on 12/13/22 at 11:32 AM, LVN B said prior to administering medication nursing staff must verify the medication against the MAR. She said the vitamin she administered to Resident #11 was incorrect because multivitamin w/ minerals and multivitamins were not the same and it resulted in Resident #11 receiving more supplementation than ordered. In an interview on 12/13/22 at 12:23 PM, the DON said that prior to administering medications to a resident nursing staff are expected to verify the patient information and medication against the MAR. She said medications should be administered as ordered and failure to do so places residents at risk for side effects, decreased therapeutic effect, side effects or allergic reactions. Record review of the facility's policy titled Medication Administration without a revision date revealed, 11- compare medication source (bubble pack, vial, etc.) with MAR to verify the resident name, medication name, form, dose, route and time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview, and record review, the facility failed to ensure that drugs and biologicals were labeled in accordance with professional principles and stored in locked compartments under proper temperature controls for 4 of 4 medication carts. (100 Hall Nursing Cart 1 , 200 Hall Med Cart 1 ,300 Hall Nursing Cart 1 and 300 Hall Med Cart 2) and 1 of 2 Medication Rooms (200 Hall Medication Room) reviewed for medication storage. - The facility failed to ensure the 100 Hall Nursing Cart did not contain inappropriately labeled insulin, and pudding without an open date - The facility failed to ensure the 200 Hall Med Cart 1 was locked when not in use and did not contain medications without an open dates and prescription medications without pharmacy labeling - The facility failed to ensure the 300 Hall Med Cart 1 was locked when not in use and did not contain insulin without an open date. - The facility failed to ensure the 300 Hall Med Cart 2 did not contain insulin without an open date. These failures could place residents at risk of adverse medication reactions and drug diversion. Findings Included: 100 Hall Nursing Cart 1 An observation and interview on [DATE] at 8:13 AM, inventory of the 100 Hall Med Cart 1 with LVN D revealed: - 2 open and in-use Insulin Glargine pen for Resident #103 without an open date, - an open and in-use Insulin Glargine pen without an open date and a pharmacy auxiliary label that read Exp. Date 28 for Resident #14, - an open and in-use vial of Insulin Lispro for Resident #101 without an open date and an auxiliary label that read Exp. Date 28 days, - an open and in-use Insulin Glargine pen without an open date and a pharmacy auxiliary label that read Exp. Date 28 for Resident #102, - An open and undated cup of pudding in the 3rd drawer, and - An open and in-use vial of Heparin for Resident #1 without an open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN D said nursing staff are expected to check their carts daily for expired and inappropriately labeled medications. She said multi-dose medications should be labeled with the date once they are opened in order to track the expiration date. She said once insulin expires it can become less effective or contaminated so it can no longer be used. LVN D said since the insulin pens and vials were undated they must be treated as expired and discarded in the drug disposal bin located in the med room. LVN D said she did not open the pudding located inside the cart and it must have been from a previous shift so it could no longer be used. She said the pudding was used to help administer medication and it should have been discarded at the end of the staffs medication pass because it could be spoiled. LVN D said that use of expired insulin and pudding could place residents at risk of GI upset, infection and uncontrolled blood sugar. 200 Hall Med Cart 1 An observation and interview on [DATE] at 07:56 AM, inventory of the 200 Hall Med Cart 1 with LVN F revealed: - an open and in use Humalog Insulin pen for Resident #100 without an open date, - an open and in use Insulin Lispro pen for Resident #54 without an open date, and - 10 packets of Pantoprazole 40 mg for delayed-release suspension without a container. LVN F said nursing staff are expected to check their carts daily for expired and inappropriately labeled medications. She said all prescription medications are specific for a single patient and should be labeled with the patient name, pharmacy name, drug name/strength/directions for use and expiration date. LVN F said all multi-dose insulin containers should be labeled with the date on the day it was opened in order to track the expiration date and any container without an open date must be discarded in the drug disposal bin in the medication room because the expiration date cannot be determined. LVN F said after insulin expires it could lose potency or become contaminated and could place residents at risk for uncontrolled blood sugars and infection. 200 Hall Med Room An observation and interview on [DATE] at 07:46 AM, inventory of the 200 Hall Med room [ROOM NUMBER] with LVN F revealed: - a plastic bag containing pudding and a box of apple cherry juice in the medication fridge LVN F said she did not know who was responsible for auditing the medication room, but the medication fridge should not contain food. She said she did not know who placed the pudding and apple cherry juice in the fridge and she would discard them in the trash. 300 Hall Med Cart #1 An observation and interview on [DATE] at 07:08 AM, inventory of the 300 Hall Medication Cart 1 with LVN G revealed, the cart was unlocked and unattended against the wall across from the 300 Hall Nursing Station. The drawers of the cart contained the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- an open and in-use vial of Levemir Insulin with an open date of [DATE] without a patient identifiers or pharmacy label inside a labeled bag for Humalog Insulin for resident #68. The insulin in the bag did not match the pharmacy label, - an open and in-use Trulicity pen (injectable medication used to treat diabetes) without an open date for Resident #68, - a NovoLog ,d+[DATE] Insulin Pen without a pharmacy labels for Resident #68 opened on [DATE], and - an open and in use NovoLog ,d+[DATE] Insulin pen without a patient identifiers or pharmacy labels. LVN G said all medication carts are expected to be locked at all times when not in use for patient safety and nursing staff must check their medication carts daily for expired and inappropriately labeled medications. She said all insulin vials/pens must be labeled with the date when opened in order to track the expiration date because once insulin expires it could lose potency and become contaminated. LVN G said if an insulin container lacks an open date, it cannot be used, and must be discarded in the drug disposal bin located in the medication storage room. LVNG said unlocked med carts and use of expired insulin could place residents at risk for drug diversion, adverse reactions, and uncontrolled blood sugars. 300 Hall Med Cart #2 An observation and interview on [DATE] at 07:34 AM, inventory of the 300 Hall Medication Cart 2 with LVN E revealed the following: - an open and in-use Humalog Insulin pen without an open date. - an open and in-use Basaglar Insulin pen for Resident #14 without an open date. LVN E said nursing staff are expected to check their carts daily for inappropriately labeled insulin containers. She said when insulin must be labeled with an open date in order to track its expiration and when insulin expires it can become infection or contaminated so it must be discarded in the drug disposal bin in the med room because use could place residents at risk of adverse reactions. In an interview on [DATE] at 12:23 PM, the DON said nursing staff must check their carts daily for expired/inappropriately labeled medications and all nurses are responsible for checking the med rooms. She said all prescription medications should have a pharmacy label which included: drug name/strength/directions for use, patient identifiers and open dates in the case of insulin. The DON said that all multi-dose injectable containers should be labeled with the date opened in order to track the expiration date because after insulin expires it can become less efficacious or contaminated. She said all expired or inappropriately labeled medications should be discarded in the drug disposal bins located in the med rooms because their use could place residents at risk of inadequate therapy, medication errors or adverse reactions. The DON said all medication carts should be locked when not in use for safety to prevent residents from gaining access to the carts resulting in injuries or adverse reactions. The DON said the medication refrigerators should not contain food and all puddings used for medication administration must be discarded immediately at the end of the drug pass because they can become spoiled placing residents at risk of GI upset if used. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Multi-dose Vials undated, 2- multi-dose vials will be re-labeled with a beyond use date, 28 days after the vial is opened or punctured (unless otherwise specified by the manufacturer). Record review of the facility's policy titled Medication Storage undated revealed, General Guidelines: a- all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls . c- during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Record review of the facility's policy titled Labeling of Medications and Biologicals undated revealed, 1- all medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices. 2- Medication labels must be legible at all times. 3- Any medication label that is soiled, incomplete, illegible, worn, or makeshift must be returned and replaced by the issuing pharmacy, not merely covered. 4- Labels for individual drug containers must include: the resident's name, prescribing physician's name, the medication name, the prescribed dose/strength and quantity, prescription number, date drug was dispense, appropriate instructions and precautions, the expiration date and the route of administration. 8- Labels for multi-use vials must include: a- the date the vial was initially opened or accessed (needle-punctured), b- all opened or accessed vials should be discarded within 28 days unless the manufacturer specifies different (shorter or longer) date for that opened vial. Record review of the facility's policy titled Insulin Pen without a revision date revealed, 2- insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency and expiration date. 3- if the label is missing, the pen will not be used; a new pen must be ordered from the pharmacy.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41469 Based on interview and record review, the facility failed to maintain a quality assessment and assurance committee consisting at a minimum the required committee members for 1 of 2 quarters reviewed for committee attendance, in that: The infection preventionist was not present for QAPI meetings from May 2022 to August 2022. This failure could place residents at risk of infections. Findings included: Record review of the QAPI Committee sign-in sheets revealed the IP never signed in for their meetings from May 2022 - August 2022. In an interview on 12/16/22 at 3:29PM, the Administrator stated the IP was hired as an IP staff in the month of February 2022. When asked if she was required to be present for the meetings, she said she would need to check the policy to see what it said. In an interview on 12/16/22 at 3:35PM the HR staff stated the IP was their only staff with an IP certification and she was hired this year. Record review of the QAPI meeting notes from May, June, July, August of 2022 revealed during those months there was no discussion on tracking and trending of infections or infection control data. [DATE] was the first month in which infection control tacking and trending was discussed due to slight increase of respiratory infections with 12 residents acquiring pneumonia. In an interview on 12/16/22 at 03:49PM, the IP stated whenever she attended the meeting, she signed in for attendance. She refused to answer whether she attended every QAPI meeting she had since being hired in March 2022. She said if she did not sign in for the meeting it must mean that she was not at the QAPI meeting on a that particular day. She stated without her present, the management would not be able to discuss reported numbers of infection rates in the facility. In an interview on 12/16/22 at 3:51PM, the Administrator stated she was hired on in the past month and she did not know the implications of not having an IP staff as part of the QAPI meeting because she had never had a meeting without one since she was hired. Record review of the IP's personnel file revealed the IP was hired on 3/07/2022 and was certified as an Infection Preventionist since 2/14/2021. Record review of the facility's QAPI program and plan, dated 2017, stated, . The QAPI committee at the minimum consists of . 4) The infection Preventionist .