STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455823	A. Building B. Wing	03/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treemont Healthcare and Rehabilitation Center	5550 Harvest Hill Rd Dallas, TX 75230

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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 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** 42627 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible for 4 residents 's (Resident #26, Resident #1, Resident #2, and Resident #3) of 21 reviewed for environment. The facility failed to ensure Resident #26's ceiling was in good condition and did not have paint pieces missing and cracked paint, Resident #1's light switch located over his head was functioning properly when pulled, and Resident #2 and Resident #3's call lights were working and had been reported to maintenance . These failures placed all residents at risk of a diminished quality of life due to an unclean and uncomfortable environment and feelings of inadequacies and delayed assistance for help with care and needs. Findings Included: Review of Resident #26's MDS dated , 01/14/22, reflected Resident #26 was initially admitted to the facility on [DATE]. The cognitive assessment reflected a BIMS score of 9 reflected a moderate cognitive impairment. An observation on 03/15/22 at 9:52 AM revealed Resident #26 was lying in bed with his eyes closed. There were pieces of the ceiling paint missing, directly above the resident's head. The ceiling also had cracked paint. An observation and interview on 03/16/22 at 7:52 AM revealed Resident #26 was lying in bed, and he was watching television. There were pieces of the ceiling paint missing, directly above the resident's head. The ceiling also had cracked paint. Resident #26 had a trach and was unable to verbalize answers but could nod his head to indicate yes and no. Resident #26 indicated he was bothered by the missing and cracked paint on the ceiling. He indicated the ceiling paint had not fallen on him. (continued on next page)

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	In an interview on 03/18/22 02:45 PM, ADM A stated his last day at the facility was 03/09/22. ADM A said floor nurses were to tell the MDS of any maintenance issues. ADM A said he was not aware of the missing and cracked paint to Resident #26's ceiling. ADM A stated it was his expectation for nurses or CNAs to place maintenance concerns in the electronic system. He stated if nurses or CNAs could not access the electronic maintenance system, he expected them to text the DON or ADM. In an interview on 03/18/22 at 3:27 PM, ADM B said her first day at the facility was 03/10/22. She stated she was not aware of the missing and cracked paint on Resident #26's ceiling. ADM B said MS would correct the issue. A record review of Resident #1 reflected he was initially admitted to the facility on [DATE] and again on 03/2/2022, and his MDS dated , 02/02/22. The cognitive assessment reflected a BIMS score of 5 which indicated he had moderate cognitive impairment. A record review of Resident #2' reflected an entry date of 10/28/2021 to the facility and MDS dated [DATE]. The cognitive assessment reflected a BIMS score of 8 which indicated moderate cognitive impairment. A record review of Resident #3 reflected an entry date of 10/28/2021 to the facility and MDS dated [DATE]. The cognitive assessment reflected a BIMS score of 12. In an interview and observation on 03/15/2022 at 9:30 AM revealed Resident #2 and Resident #3 were roommates, and both were sitting in their motorized wheelchairs. They reported their call lights had not been working. They stated they have called for assistance via call and after an hour there was no response. Resident #2 stated she needed incontinent care, and waited with no response, so she ambulated to the nurse's station to get assistance, and reported the light was not working. At that time, Resident #3 pushed the call light and after 30 minutes of no one responding, she reported this to LVN-J, and she returned to the room for observation and interviews. Resident #2 stated she was angry that staff had not responded to her needs, and she had to go and get assistance. She was still upset that the call light was not working and said they are not going to do anything about the call light if I report the issue to the facility. She stated that this has been going on for a long time. An observation on 03/15/22 at 9:52 AM revealed Resident #1 was lying in bed with his eyes opened. He asked the staff to turn off his light as he wanted to sleep. LVN-J pulled the string to the overhead light 4 times and it did not come on. Resident #1 stated the light does not work, and he has told several staff that it does not work. He said it keeps him from sleeping at night because he can't operate it independently due to the malfunction in the switch. He said that it made him feel awful and frustrated as he has complained many times and it has not been repaired. LVN-J was in the room when the resident made his statement of complaint and feelings regarding the light not working properly. In an interview with LVN-J on 3/15/2022 at 10:30 A.M. revealed he did not know the light in Resident #1's room nor the call light in Residents #2 and #3's room was not working. He stated the facility policy was for the staff to report all instances with environment concerns in the building to maintenance and they will repair or replace. He stated he would report the malfunctioning light. (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 and observation on 03/16/2022 at 10:00 a.m. with Resident #2 and Resident #3 revealed the call light in their room had been repaired and is working properly. Both Resident #2 and #3 stated they were happy about the light working. In an interview with the with the Administrator on 03/16/2022 at 11:00 a.m. a request was made to speak with the Maintenance Director. A second request was made at 2:00 p.m., to speak to the Maintenance Director and for a copy of the facility's work logs and maintenance policy. At 3:00 p.m. the Administrator provided a copy of the maintenance policy. At 5:00 p.m. on 03/16/2022, the Maintenance Director had left for the day. On 03/17/2022 the Administrator reported that the Maintenance Director would not be at work. On 03/18/2022, the Administrator reported that the Maintenance Director would not be at work. In a review of the maintenance log reflected no work orders request or repairs in Resident #1's room or Residents #2 and #3's room. In an interview with the Administrator on 03/18/2022 at 2:00 p.m., she revealed it is her expectation for the staff to document in the TELS system any maintenance issues that needed to be repaired. The Administrator stated all the staff have been trained to login and submit work orders. She proceeded to the TELS system which is the Computerized Maintenance Management System used by the facility. She did not observe a maintenance request for the light in Resident #1's room. She immediately submitted the request and maintenance repaired the light switch for Resident #1. A review of facility policy titled, TELS-UTLIZAATION GUIDELINES, revealed each staff have access to the TELS application. They are trained to access the Schedule TAB once they have logged in to the system. This tab allows team members to submit electronic work orders. Residents and visitors are to report all work orders to a team leader who will then fill out the work order on TELS. - Upon receipt of the work order, the maintenance Director will evaluate, schedule, and prioritize. - The Maintenance Director will coordinate with other department managers to ensure that tall employees are oriented on the use of the work order system through TELS. - The administrator should review all work orders weekly through TELS and discuss outstanding issues with the Maintenances Supervisor. - When a verbal request for maintenance is received from center personnel, maintenance staff should request that work order be submitted. The response should be courteous. Review of the facility's policy titled, Resident Rights and Quality of Life, dated 05/01/12, reflected residents had the right to receive services in a facility environment that is safe, clean, and comfortable

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42627 Based on interviews and record review, the facility failed to ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs for 1 (Resident #8) of 3 residents reviewed for PASRR assessments. The facility failed to ensure they correctly identified Resident #8's diagnosis of a mental disorder prior to his admission on 12/10/22. This failure placed residents with a diagnosis of MD or ID at risk for a delay in evaluation, treatment, and services provided. Findings Included: Review of Resident #8's face sheet dated 03/18/22 reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: bipolar disorder, depression, and insomnia (all these diagnoses were present on admission). Review of Resident #8's PASRR level 1 assessment, dated 12/09/21, reflected Resident #8 did not have a diagnosis of a mental disorder. In an interview on 03/17/22 at 2:21 PM, MDS Nurse F said she did not complete the PASRR level 1 for Resident #8 on 12/09/21. She said bipolar disorder was a mental illness but whether the assessment was marked yes for mental illness depended on the severity of the bipolar disorder and whether the resident has behaviors. In an interview on 03/18/22 at 9:25 AM, MDS Nurse E said residents who admitted to the facility from another facility were pre-screened at the discharging facility. She stated she reviewed the PASRR completed by the discharging facility and their diagnoses list prior to the resident's admission to ensure the accuracy of the PASRR. She stated if she noted any discrepancies in the PASRR and diagnoses, she would call the facility and ensure they corrected the PASRR prior to the residents' admission. She stated she reviewed Resident #8's PASSR prior to his admission, the PASRR was incorrect because he had a diagnosis of bipolar disorder, and she did not catch it. She stated when a resident had a possible diagnosis of a serious mental illness, she coordinated with the physician to complete another form and then she submitted the positive PASRR in the electronic system. She stated an incorrect PASRR could delay the assessment of the resident for PASRR services by the local authority. In an interview on 03/18/22 at 1:11 PM, the DON said a PASRR assessment was to be done for all residents prior to or upon admission. She said she was still learning about the PASRR process. In an interview on 03/18/22 at 2:28 PM, ADM A said he was not familiar, in depth, with the PASRR process. He stated if a PASRR was incorrect on admission, the MDS nurse should reach out to our PASRR rep and take direction on what we should do. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/18/22 at 3:23 PM, ADM B said if a PASRR was incorrect, she expected the MDS nurse to submit a corrected PASRR as soon as we realize, or anyone gets a new mental illness diagnosis. In an interview on 03/19/22 at 2:06 PM, the RDCO stated the facility did not have a policy on PASRR.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42627 Based on interview, and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #65) of five residents reviewed for quality of care. The facility failed to care plan, assess, follow physician orders to replace Resident #65's catheter monthly, and notify provider, NP K, of Resident #65's indwelling catheter monthly replacement refusals. The facility failed to routinely assess a wound to Resident #65's left groin and failed to identify an abscess had formed prior to his hospitalization on [DATE]. These failures resulted in Resident #65 being hospitalized from 03/10/22 through 03/14/22 with diagnoses of urosepsis, respiratory failure, and an abscess to his left groin. An Immediate Jeopardy (IJ) situation was identified on 03/17/22 at 11:47 AM. While the IJ was removed on 03/19/22, the facility remained out of compliance at a scope of isolated, at the severity level of actual harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures placed residents with indwelling catheters at risk for serious infections such as urosepsis, hospitalization , or death and residents with wounds at risk for worsening wounds, sepsis, or hospitalization . Findings Included: Review of Resident #65's MDS assessment, dated 02/24/22, reflected he was [AGE] year-old male admitted to the facility on [DATE]. His BIMS score was 15 which indicated he did not have a cognitive impairment. The assessment of his behavior reflected Resident #65 did not reject care and did not have any other behavioral symptoms. His functional status assessment reflected Resident #65 could perform bed mobility, transfers, locomotion off unit, and eating with supervision. The assessment reflected he required extensive one person assistance with toilet use and personal hygiene. Resident #65's urinary status was not rated, and he was always continent of bowel. His diagnoses included: peripheral vascular disease (blood circulation disorder), obstructive and reflux uropathy (when urine cannot drain through the urinary tract), diabetes mellitus, low back pain, and muscle weakness. Review of Resident #65's care plans, dated 03/18/22, revealed the plan did not address Resident #65 refusing to have his catheter replaced, replacement of the catheter, or education provided to Resident #65 regarding catheter risks or benefits. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #65's order summary report, dated 03/18/22, reflected orders entered on 03/16/22 included: Empty catheter bag every shift, Foley catheter #16 with 10mL to be changed in theER on ly as needed, and Foley catheter care twice a day and as needed. On 03/17/22 an order for a midline for IV antibiotics and an order for Meropenem 1 gram intravenously every 8 hours for a UTI. The following orders were entered on 03/18/22: Change catheter bag every two weeks and PRN, and Change foley catheter as needed. (Unless the resident has a specific order like [Resident #65] who has his changed every month in the ER. Review of Resident #65's hospital records, dated 03/15/22, reflected the resident was admitted to the hospital on 03/10/22. The records reflected Resident #65 presented to the hospital with altered mental status, he had a chronic indwelling catheter, and had a history of klebsiella (type of bacteria) UTI. The resident was given antibiotics and fluids and he became short of breath which progressed to agonal (gasping) breathing. He was intubated (tube inserted into the trachea for artificial ventilation), placed on a vent (machine for artificial ventilation that delivers air or oxygen) and was admitted to the ICU. His diagnoses included: severe sepsis (with MDR Klebsiella and Proteus [bacteria]) in the setting of chronic indwelling urinary catheter, acute respiratory failure, acute kidney injury, abscess of left groin, and ischemic cardiomyopathy (heart's decreased ability to pump blood properly, due to heart damage), complex PVD, iliac aneurysm (bulging and weakness in the wall of the iliac artery), chronic back and lower extremity pain, and urinary incontinence. The records reflected Resident #65 had an indwelling urinary catheter due to a history of ureteral stricture (scarring that narrows the tube that carries urine out of the body) and the foley was being managed by an outpatient urologist. The ICU doctor ordered to maintain the indwelling foley, consult urology to change the foley because the resident had a history of difficult placement and was likely the source of the resident's infection given his history of klebsiella and group b strep (type of bacteria) UTI. The ICU doctor documented, Due to a high probability of clinically significant, life threatening deterioration, the patient required my highest level of preparedness to intervene emergently, and I personally spent this critical care time directly and personally managing the patient . This critical care time was performed to assess and manage the high probability of imminent, life-threatening deterioration that could result in multi-organ failure . The resident was extubated (removal of tube used for artificial breathing) on 03/11/22. A foley catheter was placed on 03/11/11 by a physician. On 03/10/22, Resident #65 labs showed: WBC 17.2 H (normal 4.5 to 11; high indicated infection); sodium 128 L (normal 135 to 145); UA showed a pH of 9.0 H (normal 4.6 to 8); ABG reflected a pH of 7.079 (critical low, normal 7.35 to 7.45. Indicated extreme acidosis, a common feature of many acute/critical conditions that warrant admission to intensive care unit). Review of the facility provided documentation of each time Resident #65's foley catheter was replaced reflected the following documented in progress notes: 1. 10/15/21- nurse documented the resident was sent to the hospital for a catheter replacement due to leakage. 2. 12/12/21- nurse documented Resident #65 refused to have his foley catheter changed and stated it would be changed at the doctor's office. 3. 02/01/22- nurse documented the resident was sent to the hospital for a foley catheter replacement. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. 03/16/22- NP K documented the intermittent issue, chronic foley needs Urology to follow [due to] difficulty replacing foley. foley has been replaced 10/16 in the hospital replaced again 11/17. Replaced 02/01/22. Review of an outside referral form dated 09/13/21 reflected Resident #65 was referred to urology by MD L for foley catheter replacement once a month. Review of Resident #65's TAR for September 2021 reflected an order for the resident to be referred to the urologist on 09/18/21 for catheter management. Review of Resident #65's wound assessments reflected Resident #65 had a wound assessment on 02/07/22 and did not have another wound assessment until 03/09/22. The assessment on 03/09/22 reflected a surgical wound to Resident #65's groin which was present on admission. Wound measurements were area 1. 4 cm squared, length 1.6 cm, width 1.6 cm, and depth was not applicable. The assessment of the wound on 03/16/22 after Resident #65 returned from the hospital reflected a surgical wound to his groin, and the measurements were area 3.9 cm squared, length 2.6 cm, width 2.3 cm, and depth was not applicable. Review of Resident #65's weekly skin assessments on the following dated: 12/21/21, 02/02/22, 2/10/22, 02/17/22, 02/24/22, 03/03/22, and 03/10/22 all reflected his skin condition as normal and indicated there were not any new wounds. Review of Resident #65's February 2022 and March 2022 MARs and TARs reflected the following order with a start date of 02/14/22: Cleanse wound to left groin with normal saline, pat dry, apply calcium alginate, and cover with dressing daily. The following dates were not initialed as completed: 02/20/22, 03/01/22, 03/02/22, 03/05/22, and 03/09/22. Further review reflected Resident #65 did not have an order for catheter care. Resident #65 had an order for changing his foley catheter once a month on the 10th of every month which was scheduled to be completed at 11 PM. In an interview on 03/16/22 at 12:15 PM, Resident #65 said he had lived at the facility for a year. He said he had an indwelling foley since his admission into the facility because of a spinal injury that caused him to not be able to feel when he needed to void. Resident #65 said he was hospitalized from 03/10/22 until 03/15/22 due to an infection in his penis. Resident #65 said he could not recall any of the events leading to his hospitalization , and said the next thing I knew, I was in the hospital, in the ICU. Resident #65 said he was unaware his foley catheter was to be changed monthly. Resident #65 said the nurses at the facility had never replaced his indwelling foley. Resident #65 said he had refused for the nurses to replace his catheter a couple of times before because anytime they attempted to change it, it was in the middle of the night, and because he thought only a doctor or nurse practitioner were able to replace his indwelling catheter. Resident #65 said he was unaware an abscess had developed in his left groin area and was unaware if it was treated in the hospital. Resident #65 said his family member was with him at the facility and she called 911 on 03/10/22. Resident #65 gave HHSC Surveyor his family member's telephone number and requested she be interviewed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 03/19/22 at 10:49 AM, LVN M said she had never replaced Resident #65's foley catheter because it was scheduled to be changed on the night shift. She said she was his nurse on 03/10/22 and on that morning she checked his blood sugar, gave him insulin, and gave him Norco because he always wants pain meds. LVN M said CNA G assisted him in getting ready for his appointment. LVN M said Resident #65 looked sleepy in the morning. LVN M said when Resident #65 returned from his appointment he went to the nurse's station at around 1:30 PM and informed her he was back and requested to go to bed. She said CNA G was going to look for another person to assist with a transfer and he went to the room to wait for the CNAs. LVN M at around 1:50 [PM] CNA G came to tell me [Resident #65] was on the floor. LVN M said Resident #65 was not a fall risk and he usually did things by himself and transferred himself. LVN M said when she went to see Resident #65, he was lying flat on his back on the floor. LVN M said she asked him if he hit his head, and he said no. LVN M said she checked Resident #65's vital signs, helped get him into the bed. LVN M said she did not check Resident #65's blood sugar at that time. LVN M said she notified the doctor and the RP of Resident #65's fall. LVN M said the doctor gave her instructions to monitor because Resident #65 said he didn't hit his head. LVN M said CNA G did not tell her Resident #65 looked different or that Resident #65 had told her he did not feel well. LVN M said if CNA G had given her that information, she would have called the doctor and told them about all the changes and would suggest getting some bloodwork or a UA. In an interview on 03/16/22 at 3:10 PM, LVN H said she was assigned to work with Resident #65 and regularly worked with him. She said Resident #65 had an order to change the foley catheter monthly, but he refused. LVN H said she could not recall if she documented his refusals or notified the provider. LVN H said Resident #65 was able to empty his own foley drainage bag and indicated he did not need an indwelling catheter. LVN H said the reason's Resident #65 had a catheter were all in here, while pointing at her head. LVN H was not aware if Resident #65 had an order for catheter care and when asked if she had performed catheter care for Resident #65, LVN H stated, [Resident #65] does what [Resident #65] wants, and did not answer if she had performed catheter care for Resident #65. In an interview on 03/16/22 at 3:14 PM, RN O said she worked with Resident #65 routinely but had not worked with him since January 2022. She said previously there was an order to send Resident #65 to the hospital to replace his foley catheter but she not aware of the last time it was changed. RN O said Resident #65 was able to call 911 on his own when he noted his catheter was leaking and it needed to be changed. RN O did not know if Resident #65 had an order for catheter care. (continued on next page)

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	455823	A. Building B. Wing	03/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treemont Healthcare and Rehabilitation Center	5550 Harvest Hill Rd Dallas, TX 75230

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 03/16/22 at 3:18 PM, the DON said Resident #65 was very alert and very verbal. She said if anything was wrong with him, or pain, he'll go to the nurse. The DON said if the nurse did not respond right away, Resident #65 would go to her. She said Resident #65 had been at the facility for a year and was admitted with a foley catheter and a sore on his left groin and the wound was not healing. The DON said Resident #65 was previously referred to a urologist, but his insurance had denied the referral. The DON did not know if the physician or NP K was notified Resident #65's insurance had denied the urology consult. The DON reviewed Resident #65 February 2022 TAR in the electronic record and said Resident #65's foley catheter replacement was scheduled on the 10th of the month at 11 PM because that was when the facility scheduled foley catheter changes, on the 10 PM to 6AM shift. She said she was unaware that was one of the reasons Resident #65 refused to have his foley catheter replaced. The DON said she was not aware Resident #65 did not have orders for catheter care and because he was in an out of the hospital, the orders for catheter care must have been missed on one of his re-admission orders. The DON said she was also the facility's WCN, and Resident #65 was not seen by a wound care doctor, and he was followed by MD P, who was a vascular surgeon. The DON said she saw the wound the day before he went to the hospital on 03/09/22 and she did not see an abscess. The DON said she was responsible for completing wound care on 03/01/22, 03/02/22, and 03/09/22 and wound care assessments weekly. The DON said they were not completed because she had a lot of new responsibilities as the DON, and it was difficult maintain her duties as WCN as well. She said at times she delegated for the charge nurses to do the wound care. Documentation of each time Resident #65's foley catheter had been replaced since September 2021 was requested by HHSC surveyor. The records provided did not reflect Resident #65's foley catheter was changed: September2021, December 2021, and January 2022. In a telephone interview on 03/17/22 at 12:24 PM, NP K said she was not aware Resident #65 was refusing having his indwelling catheter replaced and she expected to be notified of any refusals. NP K said she expected catheter care to be done daily and as needed and did not know if Resident #65 had an order for catheter care because it should be a facility protocol. NP K said she was not notified Resident #65 could not see a urologist due to insurance issues, stated she should have been notified, and felt Resident #65 needed to be seen by a urologist. In an interview on 03/17/22 at 12:30 PM, MD L said it was likely he was Resident #65's primary physician. He said he did not remember all of their names but Resident #65 sounded familiar. MD L said he was aware Resident #65 frequently refused to have his catheter replaced and obviously we are trying to get the patient to comply with standard of care and getting his catheter routinely replaced and obviously there's a higher risk for urosepsis the longer it stays in there. MD L said he did not remember if he personally educated Resident #65 on his indwelling catheter. MD L said, There's little we can do, a lot of patients have mental health clouding their issues. They're not compliant patients. MD L said he did not have any comment on that resident believing only a doctor or nurse practitioner could change his indwelling catheter. MD L said, We made every attempt to get him to a urologist but cannot control insurance. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 03/18/22 at 12:57 PM, the DON said if a resident refused to have their indwelling catheter replaced, she expected the nurse to document in a progress note and notify the on-call provider. The DON said she spoke with Resident #65 and he told her having the indwelling catheter replaced hurt him and told her only a doctor could replace it. The DON said she did not know if Resident #65 had trauma to his urethra. The DON said she had talked to the SW because Resident #65 wanted a urologist to see him, but she did not know when that occured. The DON said she asked Resident #65 if he had a urologist and she did not remember what Resident #65 said so the SW was looking for a urologist. The DON said all the urologists around the area did not take Resident #65's insurance. The DON said it had not been discussed for the facility doctor to replace Resident #65's indwelling catheter because the doctor that comes here is the NP, [MD L] doesn't even come. He comes once a month for QAPI meeting. The DON said Resident #65 had been in and out of the hospital so the order for catheter just dropped, indicating the orders for catheter care had been omitted and not re-started on one of Resident #65's re-admission order sets. In an interview on 03/18/22 at 1:49 PM, the SW stated Resident #65 had an order for a urology consult since September 2021. The SW said the outpatient clinic to which Resident #65 was referred took a long time, they said it could take from 14-90 days for Resident #65 to get an appointment. The SW said he looked up clinics online that accepted Resident #65's insurance, but when he called, none accepted Resident #65's insurance. The SW said he recently spoke with the case worker at Resident #65's insurance company and he told them he was having trouble and they sent him a list of 3 doctors. He said when he contacted those doctor's offices, they told him they did not accept his insurance. The SW said he thought the facility would cover the cost for the resident to see a urologist if a resident is private pay, then their provider will say get them seen right now. The SW said certain residents may need to pay private to see a specialist. The SW said he had never had a situation of not finding a specialist for a resident and he thought it would be the ADM that would make that decision to cover the cost for the specialist. The SW said Resident #65 told him he had been going to the hospital to have his foley catheter replaced and the hospital nurse and doctor had told Resident #65 that as long as he did not have a urologist, he could go to the hospital to get it changed. The SW said Resident #65 was very vocal about what he wants, and Resident #65 knew when his foley catheter needed to be changed. The SW said it was discussed multiple times in the facility's daily morning meeting, which ADM A and the DON attended, that nurses were hesitant to change Resident #65's indwelling foley because there was complications, and they were not able to do it here. The SW said when Resident #65's catheter replacement came up in the morning meetings, the plan discussed was to find the urologist, which was his responsibility. In an interview on 03/18/22 at 2:13 PM, ADM A said Resident #65 refuses to get the catheter removed; we do educate him on that, well, nursing does. He said Resident #65 had mentioned he wanted a urologist's opinion, and the facility had made several appointments but then they were told they did not accept Resident #65's insurance. ADM A said Resident #65 had been at the facility for about a year and the foley catheter became an issue around September 2021. ADM A said Resident #65 did not want the foley catheter removed because he did not want to wear adult briefs and did not like to be wet. ADM A said Resident #65 was using the need for a urologist as an excuse to not having the foley catheter removed. ADM A said Resident #65 was content with the foley. ADM A said if a urologist who accepted Resident #65's insurance could not be found, the facility would cover the cost for him to see a urologist. ADM A said anytime Resident #65 when to the ER he saw a urologist. ADM A said, If it was an emergency, the facility would cover the cost for a urologist. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 03/19/22 at 12:13 PM, MDS Nurse E said she was aware Resident #65 refused to have his foley catheter replaced with one night nurse and she said, some people have said [Resident #65] refused. MDS Nurse E said she care planned Resident #65 for refusing to wear a privacy bag but did not remember if she had care planned the refusals of having his foley catheter changed. MDS Nurse E said she went to meet with Resident #65 and asked him why he refused having his indwelling catheter replaced, and he stated because only a doctor could replace it. MDS Nurse E did not recall when she spoke to Resident #65 or if she had documented their conversation. MDS Nurse E said she spoke with the SW and asked that he to try to find someone to replace Resident #65's indwelling catheter. MDS Nurse E stated Resident #65's foley catheter replacement refusals should have been care planned. In an interview on 03/18/22at 03:37 PM, ADM B stated her first day working at the facility was 03/10/22 and she was not aware of any concerns regarding Resident #65's foley cath. ADM B said, we stepped in this morning and got [Resident #65] an appointment with a urologist. ADM B said it did not matter if a resident's insurance did not cover the cost for them to see a specialist. She said it was the facility's responsibility to pay for them to be seen if needed. ADM B said after a reasonable attempt was made to find a specialist in network, the facility should step in to have the resident seen. ADM B said the time she expected to elapse in finding an in-network specialist should be a week or so, but if the need was urgent, they should not wait even a week. Review of the facility's undated policy titled urinary elimination reflected in part: Record and report the reason for catheterization, type, and size of catheter inserted . record amount of urine on intake and output (I&O) flowsheet record in the EHR or chart . Report persistent catheter-related pain, inadequate urine output, and discomfort to healthcare provider . Document your evaluation of patient learning . Symptoms of a UTI in an older adult may be difficult to recognize and may only be indicated by a change in mental status . older adults have increased risks for UTI . Providing regular perineal hygiene, preventing catheter-related trauma, and removing indwelling catheters as soon as possible are important interventions to reduce the risk of [CAUTI]. Review of the undated facility form titled Indwelling Cath Audit Tool reflected nurses were expected to relate the reason for the indwelling catheter, record output appropriately or as ordered, complete pericare during catheter care, and verify the physicians order included an acceptable diagnosis for indwelling catheter use. Review of the untitled facility policy titled, Wound Care, reflected the following: Facility has a treatment who completes . weekly skin and wound evaluations on all ulcers and surgical wounds. This includes taking weekly photos and measurements. Rounds with the Wound Physician once a week. Charge nurse completes initial assessment and treatment on all skin/wounds . if the treatment nurse in not available in the facility, the Charge Nurses will be responsible for the initial assessment of all pressure injuries and surgical wounds . Charge nurse will notify the physician/NP and responsible party of all new wounds and document notification with the RP's name. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to the website https://www.merckmanuals.com/professional/genitourinary-disorders/urinary-tract-infections-utis/catheter-associated-urinary-tract-infections, accessed on 03/25/22, .A catheter-associated urinary tract infection (UTI) is a UTI in which the positive culture was taken when an indwelling urinary catheter had been in place for > 2 calendar days. Patients with indwelling bladder catheters are predisposed to bacteriuria and UTIs. Symptoms may be vague or may suggest sepsis. Diagnosis depends on the presence of symptoms. Testing includes urinalysis and culture after the catheter has been removed and a new one inserted. The most effective preventive measures are avoiding unnecessary catheterization and removing catheters as soon as possible . According to the website https://www.merckmanuals.com/professional/critical-care-medicine/sepsis-and-septic-shock/sepsis-and-septic-shock, accessed on 03/25/22, . Sepsis is a clinical syndrome of life-threatening organ dysfunction caused by a dysregulated response to infection. In septic shock, there is critical reduction in tissue perfusion; acute failure of multiple organs, including the lungs, kidneys, and liver, can occur. Common causes in immunocompetent patients include many different species of gram-positive and gram-negative bacteria . Signs include fever, hypotension, oliguria (abnormally small amounts of urine), and confusion. Diagnosis is primarily clinical combined with culture results showing infection; early recognition and treatment is critical. Treatment is aggressive fluid resuscitation, antibiotics, surgical excision of infected or necrotic tissue and drainage of pus, and supportive care . An Immediate Jeopardy (IJ) situation was identified on 03/17/22 at 11:47 AM. ADM A, ADM B, the DON, and the RDCO were notified, and a POR was requested. While the IJ was removed on 03/19/22, the facility remained out of compliance at a scope of isolated, at the severity level of actual harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. The POR reflected the following: Two identified residents with indwelling urinary catheter. One identified resident with indwelling catheter and groin wound, who was hospitalized with sepsis. 1. Director of Nursing Services verified resident's catheter orders 3.17.22. Director of Nursing Services 3.16.22 2. LNAC, MDS updated resident's care plan to include catheter care 3.17.22. LVN, LNAC, MDS LVN, Director of Care Coordination 3.17.22 3. Director of Nursing Services reviewed physician orders, pertaining to the resident's catheter, with the resident 3.17.22 Director of Nursing Services 3.17.22. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. The Director of Clinical of Operations, RN, WCC, CDP will educate the DNS, ADNS, LNAC, RNAC, and DCC related to updating Catheter care plans, assessing catheters upon admission and as needed, inputting orders, change in condition using the Interact Program, assessing wounds and following all MD orders related to wounds. Initiated 3/17/22, Complete 3/18/22 Midnight, DCO 5. Director of Care Coordination began education with nursing staff 3.17.22. Education includes assessing catheters upon admission and as needed, inputting orders and updating care plans related to catheter care. Also, Change in Condition, using the Interact Program. Director of Care Services 3.17.22 6. Director of Clinical Operations and Director of Nursing Services explained the Risk vs Benefits of having an indwelling catheter to the resident 3.17.22. Resident chose to keep the catheter at this time. Director of Clinical Operation and Director of Nursing Services Initiated 3.17.22 One identified resident with a surgical wound to the left groin. 1. Upon the residents return from the hospital, on 3.16.22, Director of Nursing Services assessed the surgical wound, to the resident's groin area. Photos were taken of the wound. There were no signs of infection and the resident did not exhibit any signs of poor care. Director of Nursing Services 1.16.22. 2. Director of Nursing Services verified the residents wound care orders on 3.16.22. Director of Nursing Services 3.16.22 3. LVN Charge Nurse assessed wound on 3.17.22. Nurse verified proper staging, correct treatments, and preventive measures in place 3.17.22. There were no signs of infection or evidence of poor care. A LVN, Charge Nurse 3.17.22 4. LVN, Charge Nurse assessed all residents who have wound care orders 3.17.22, to ensure orders were being followed for proper wound care with documentation completed. LVN, Charge Nurse 3.17.22 5. LNAC, MDS updated the resident's care plan 3.17.22. LNAC, MDS 3.17.22 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. The Director of Clinical Operation, RN, WCC, CDP will educate the DNS, ADNS, LNAC, RNAC, and DCC related to updating Catheter care plans, assessing catheters upon admission and as needed, inputting orders, change in condition using the Interact Program, assessing wounds and following all MD orders related to wounds. Initiated on 3/17/22, Complete 3/18/22, DCO 7. Director of Care Coordination began educating all nursing staff on assessing wounds and following all MD orders related to wounds 3.17.22. Director of Care Coordinator 3.17.22 One other resident identified with an indwelling catheter. 1. The [TRUNCATED]

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42627 Based on observations, interviews, and record reviews, the facility failed to ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers for 1 (Resident #33) of 3 residents reviewed for pressure ulcers. The facility failed to ensure Resident #33 wore the care planned boots to her bilateral feet which were an intervention used to prevent the development of pressure ulcers. This failure placed residents at risk for the development of avoidable pressure ulcers. Findings included: Review of Resident #33's MDS Assessment, dated 01/26/22 reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: diabetes mellitus, hemiplegia (paralysis of one side of the body), and unstageable pressure ulcer to left heel. The skin condition assessment reflected Resident #33 was at risk of developing pressure ulcers and the resident did not have any unhealed pressure ulcers. Review of Resident #33's care plans, dated 03/16/22, reflected she had an actual or was at risk for pressure ulcers due to being bed fast, Braden score 18 or less (indicating a mild risk for pressure ulcers), diagnosis of diabetes, obesity, and the presence of edema. The interventions included float heels, and heel boots. In an observation on 03/15/22 at 9:50 AM, CNA N and the RC were providing Resident #33 with incontinent care. After care was provided, Resident #33 was positioned on her back. Her heels were not floated, and she did not have heel boots to her feet. There were no visible wounds to either of Resident #33's feet. In an observation on 03/16/22 at 7:03 AM, Resident #33 was lying on bed on her back. She was resting with her eyes closed. Her heels were not floated, and she did not have heel boots to her feet. In an interview and observation on 03/18/22 at 1:21 PM, the DON said Resident #33 was to wear heel boots at all times due to a history of a stage 4 pressure ulcer to her left heel. An observation revealed Resident #33 was in bed, resting with her eyes closed. She did not have heel boots on, and her heels were not floated off the bed. The DON obtained the heel boots from Resident #33's closet and placed them on Resident #33's feet. The DON stated Resident #33 was at risk for the development of pressure ulcers to her heels if wound prevention measures, such as heel boots, were not implemented. In an interview on 03/19/22 10:33 AM, CNA G said she was assigned to work with Resident #33 on 03/16/22 on the 6 AM to 2 PM shift. CNA G said she did not know if Resident #33 had a history of pressure ulcers. CNA G said Resident #33 did not have any sores. She said Resident #33 was to wear heel protectors on her feet because she thought Resident #33 had a wound to her heel a while back. CNA G said she did not remember if she placed the heel protectors on Resident #33 on 03/16/22. CNA G said the heel protectors were to make sure Resident #33 did not get sores on her heels. CNA G said Resident #33 should have her heel protectors in place at all times. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Skin Care Guidelines, dated July 2018, reflected: . To provide a system of evaluation of skin to identify risk and to identify individual interventions to address risk and a process for care of changes/disruption of skin integrity . the plan of care will address problem, goals and interventions directed toward prevention of pressure ulcers in those at risk and for any skin integrity concerns identified

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42627 Based on observation, interview, and record review, the facility failed to ensure that residents receive proper treatment and care to maintain good foot health for 1 (Resident #8) of 2 residents reviewed for foot care. The facility failed to identify a callous to Resident #26's left foot, provide foot care and treatment and assist the resident in making and appointment with the podiatrist. These failures placed all residents at risk for not receiving foot care which is consistent with professional standards of practice. Findings included: Review of Resident #8's face sheet dated 03/18/22 reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: type 2 diabetes, peripheral neuropathy (damage to the nerves located outside of the brain and spinal cord, often causes weakness, numbness, and pain, usually in the hands and feet), and peripheral vascular disease (circulation disorder). Review of Resident #8's orders, dated 03/18/22, reflected the following orders entered on 12/10/21: May see podiatrist ., and Weekly skin reviews Review of Resident #8's admission assessment, dated 12/10/21, reflected there was not a skin alteration documented to Resident #8's left foot. Review of Resident #8's weekly skin assessments on: 12/20/21, 12/27/21, 01/03/22, 01/10/22, 01/17/22, 01/24/22, 02/07/22, 02/14/22, 02/21/22, 02/28/22, 03/07/22, 03/14/22 all reflected no wounds and skin condition as normal. An observation and interview on 03/15/22 at 10:43 AM revealed Resident #8 stated he had been at the facility since 12/10/21. Resident #8 stated he was admitted to the facility for rehabilitations due to a broken right hip. Resident #8 stated he had a wound to his left foot and had requested to see a podiatrist about two weeks ago. Resident #8 could not recall who he had spoken to regarding seeing a podiatrist. An observation of Resident #8's left foot revealed he had a circular nickel size area of dry, hard skin to the bottom of his foot in the metatarsal area (area below the great toe). The center of the circular area was a darker color approximately 0.5 cm. Resident #8 stated the area was tender to touch and it made it difficult for him to walk. Resident #8 stated he had a diagnosis of diabetes and he also smoked. An interview on 03/16/22 at 1:45 AM revealed LVN H was assigned to work with Resident #8. LVN H said she was not aware of a wound to Resident #8's left foot. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 03/16/22 at 1:49 PM, the DON said she was not aware of a wound to Resident #8's left foot. The DON entered Resident #8's room and observed the bottom of Resident #8's foot and stated it was a callous that looked old. The DON stated she was not notified Resident #8 wanted to see podiatrist. The DON said the callous should have been documented on Resident #8's admission skin assessment. The DON reviewed Resident #8's admission assessment and stated the callous was not documented on admission assessment. The DON stated Resident #8 should have been followed by podiatry because he was diabetic, and he could develop a wound and healing was slow for residents with diabetes. The DON said LVN H would call the doctor and get an order for a podiatry consult. The DON stated the SW was responsible for scheduling podiatry consults once an order was obtained. In an interview on 03/16/22 at 2:05 PM, the SW stated he was not aware Resident #8 had asked to see a podiatrist. The SW looked at his appointment schedule and said the podiatrist came to the facility every Tuesday. The SW stated Resident #8 was not seen by podiatry last week (03/08/22) or this week (03/15/22). Review of the facility policy titled Skin Care Guidelines, dated July 2018, reflected: . To provide a system of evaluation of skin to identify risk and to identify individual interventions to address risk and a process for care of changes/disruption of skin integrity . the plan of care will address problem, goals and interventions directed toward prevention of pressure ulcers in those at risk and for any skin integrity concerns identified

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42627 Based on observation, interview, and record review the facility failed to ensure residents receiving enteral feeding received appropriate care and services to prevent complications of enteral feedings for 2 (Resident # 26 and Resident #33) of 2 residents reviewed for enteral feedings. The facility failed to properly set up the tube feeding pump and to monitor Resident #26 received the water ordered prior to and after his hospitalization . This resulted in Resident #26 receiving too much fluid after a provider ordered a decrease in the resident's free water order on 02/28/22. Resident #26 required dialysis (a procedure where a dialysis machine and a special filter called an artificial kidney, or a dialyzer, are used to clean your blood) for ESRD. 1. The facility failed to ensure Resident #33 was not laid flat in bed during incontinent care while her enteral feeding was still running. This failure placed residents with enteral feedings at risk of receiving inappropriate care and maintenance which could result in fluid overload, dehydration, vomiting, aspiration (entering the airways or lungs), hospitalization , or death. Findings Included: Review of Resident #26's MDS dated , dated 01/14/22, reflected Resident #26 was a [AGE] year-old male initially admitted to the facility on [DATE]. The cognitive assessment reflected a BIMS score of 9, indicating a moderate cognitive impairment. His diagnoses included: ESRD (medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), epilepsy, respiratory failure, muscle wasting, dysphagia (difficulty swallowing), and cerebrovascular disease. The assessment reflected Resident #26 had a feeding tube and received his nutrition and hydration via the tube. The functional status assessment reflected he required extensive two-person assistance with bed mobility and was totally dependent on two-person assistance for dressing, toilet use, and personal hygiene. Review of Resident #26's orders in the electronic health record on 03/17/22 reflected he had an order to infuse Nepro with Carb Steady at 50cc/hr for 22 hours and free water infused at 100ml every 6 hours for 22 hours via pump and this order had been initiated on 02/28/22. Review of Resident #26's care plans in the electronic health records on 03/16/22 reflected he had a tube feeding of Nepro (g-tube formula) due to a diagnosis of dysphagia. Interventions included: The resident needs what assistance/supervision/cueing) with tube feeding and water flushes. See MD orders for current feeding orders, and Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #26 labs dated 03/08/22 reflected the following: 1. 02/28/22- Sodium 127 L (normal range 136-145) (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. NP K note on 03/01/22 at 1:59 PM reflected: .3/1 personally changed free water flush to [feeding] pump . New problems: debility . hyponatremia . Consultants requested: Dietician, Renal 9. RN O note on 03/02/22 at 1:37PM reflected: Received new order for Bmp 10. NP K note on 03/02/22 at 8:31 PM reflected: . 3/2 spoke with dietician . Tube feed diet. NPO . Plan . bmp tomorrow [03/03/22] . 11. RN O note on 03/03/22 at 1:17 PM reflected: Bmp result out and sodium 123 [low]. Called and spoke with [NP K] who said to transfer [him] to the hospital. 12. NP K note on 03/03/22 at 7PM reflected: The nurse reported a critical sodium level of 123, [patient] will need to be sent out for ER [evaluation] for severe hyponatremia 13. RN O note on 03/03/22 at 7PM reflected: Resident transferred to [hospital] in the company of [non-emergency ambulance] transport company with his paperwork for sever hyponatremia 14. LVN I note on 03/07/22 at 6:55 PM reflected: .arrived from [hospital] . under the care of [MD L] . [diagnoses] acute upper GI bleed, volume overload, acute kidney injury superimposed on chronic kidney disease, hypo-osmolality, and hyponatremia . Diet: NPO. Resume prior tube feeding orders with Nepro infuse at 50cc/hr x 22 hours and free water infuse at 20cc/hr x 22 hours 15. LVN I note on 03/07/22 at 7:06 PM reflected: . called [MD L] on-call phone and notified [NP Q] about resident re-admit. Also reviewed all new orders to her. Agreed to carry out order with some further orders given. Labs: CBC with [differential] and CMP in AM [03/08/22] . and to resume all prior [g-tube] feeding orders . 16. RN C note on 03/08/22 at 1:59 AM reflected: . Nepro at 50cc/hr with free water flush at 20cc/hr 17. RN O note on 03/08/22 at 1:56 PM reflected: Received new order for BMP STAT. IV sodium chloride 75cc/hr x 2liters . all IV department for midline placement. 18. NP K note on 03/08/22 at 2:06 PM reflected: Lab date . [Sodium] 125 . New Problems: debility . hyponatremia . ordered IVFs 3/8- informed DON and nurse . muscle twitching . Myoclonus? [quick, involuntary muscle jerk] . [patient] unable to hold items . Plan: . bmp every other day . [normal saline] IVFs ordered . if sodium level does not improve, [patient] will need to be sent out again to ER . Consultants requested: PT/OT, Renal 19. RN C note on 03/09/22 at 6:51 AM reflected: Sodium Chloride solution 0.9% . IV line pending. 20. RN O note on 03/09/22 at 9:37 AM reflected: Received new order from [MD R] nephrologist to discontinue sodium chloride solution. 21. NP K note on 03/11/22 at 1:16 PM reflected: . 3/9 spoke with dialysis nurse, reports nephrologist does refuse more IVFs .monitor sodium levels . Consultants Requested: pulmonary, dietician, renal (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	22. RN O note on 03/11/22 at 3:50 PM reflected: Resident remain on in house dialysis . continued tube feeding with nepro 1.8 cal at the rate of 50cc/hr [water] flush 20ml/hr 23. RN O note on 03/14/22 at 2:10 PM reflected: Resident remain on in house dialysis . continued tube feeding with nepro 1.8 cal at the rate of 50cc/hr [water] flush 20ml/hr. 24. NP K note on 03/15/22 at 7:20 PM reflected: .monitoring sodium levels, need new lab draw . Plan . monitor sodium levels . bmp tomorrow . Consultants requested: pulmonary, dietician, renal 25. RN O note on 03/16/22 at 10:36 AM, was struck out on 03/17/22 at 7:09 PM reflected she had documented Resident #26 was receiving a water flush set to 20mL per hour. She also documented Resident #26 was messing with tube but redirected. 26. RN S note on 03/16/22 at 9:36 PM reflected RN S discovered Resident #26 with his g-tube pulled out and lying on the bed. Resident was not able to state what happened and the nurse called non-emergency ambulance to transport the resident to the hospital. 27. RN C note on 03/17/22 at 2:30 AM reflected Resident #26 returned from the hospital with a g-tube replacement. Review of Resident #26's MAR and TAR from February 2022 and March 2022 reflected he had an enteral feed order for free water at 20mL/hr for 22 hours daily which was discontinued on 02/28/22. On 03/01/22 a new enteral order was entered for free water at 100mL every 6 hours x 22 hours. This order was in place from 03/01/22 until 03/19/22 (the last date documented/reviewed on the MAR). An observation on 03/15/22 at 9:52 AM revealed Resident #26 was lying in bed with his eyes closed. He had a g-tube which was connected to a feeding pump infusing Nepro 1.8 with carbsteady at 50mL/hr and water flush was set to 20mL/hr. An observation on 03/16/22 at 7:52 AM revealed RN O entered Resident #26's room to give him his medications. RN O disconnected Resident #26's g-tube from the feeding pump and turned off the pump. She then tried to flush the g-tube with 15mL of water, but the g-tube was clogged. RN O milked the g-tube and after it became unclogged, she administered 30mL of water, pushing it into the g-tube using a 60mL syringe and plunger. RN O then removed the syringe from Resident #26's g-tube and proceeded to flush the tube with another 30mL of water by gravity and then administered a total of 8 medications (which had been mixed with approximately 5-10mL of water) separately. RN O flushed the g-tube with approximately 5-10mL of water between each medication. RN O then flushed the tube with 30mL of water. RN O administered to Resident #26 a total water volume between 165mL to 240 mL during the medication pass. She then reconnected Resident #26's g-tube to the feeding pump, and the pump was set to deliver the formula at 50mL per hour and the water flush was set to deliver 20mL per hour. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation on 03/17/22 at 5:11 PM, RN O stated she checked the feeding pump settings at the beginning of her 6AM to 2PM shift and would compare the settings to the order. RN O said she was working with Resident #26 on 03/17/22. She said she checked the settings on his feeding pump the morning of 03/17/22. RN O said Resident #26 was hospitalized from 03/03/22 until 03/07/22 due to hyponatremia. She said NP K had given an order for normal saline IVF but dialysis refused; they're still battling with it. RN O said if a resident has prolonged hyponatremia that could lead to arrhythmias, such as atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), and a person could go into a coma if not handled. RN O said after Resident #26 returned from the hospital, dialysis continued with the same dialysis and dialysis is managing now. RN O said Resident #26 g-tube had been clogged at least twice when she worked with him and she did not recall if she documented the additional water that was given or if she notified the provider. An observation of Resident #26's feeding pump settings with RN O revealed the pump was set to deliver 20mL per hour, instead of the 100mL every 6 hours. RN O said the setting was not correct and said, I'm so sorry, and corrected the water flush setting. RN O stated she was not aware why the setting was not correct per the order and stated she had not changed the setting previously on her shift that day, 03/17/22. In a telephone interview on 03/17/22 4:32 PM, NP K said she had ordered the change to Resident #26's water flush on 02/28/22 to 100mL every 6 hours because that was what he had been receiving previously and thought that may correct his hyponatremia. NP K said she noted on 03/01/22 that her flush order change had not been implemented, she corrected the pump setting herself to 100mL every 6 hours and notified RN O. NP K said she talk to the doctor that she worked with and would continue to monitor Resident #26's free water intake. NP K said she did not think the nephrologist wanted to do anymore IV sodium fluids. In an interview on 03/18/22 at 9:21 AM, RD P said she was the facility's dietician. She said Resident #26 had a long-standing history of enteral feedings. She said in the past he had done better with speech therapy and they had started oral feedings. She said Resident #26 had an MBSS on 05/11/21 that showed he aspirated on all consistencies and Resident #26 was reverted to 100% enteral feeding and NPO. RD P said Resident #26 received in room hemodialysis three times a week. She said recently NP K changed Resident #26's free water flush to 100mL/q6h because she wanted to pursue to see if it corrected the hyponatremia. RD P said BMP results went to the physician and they were monitoring his sodium levels closely because Resident #26 had multiple organ failure. RD P said Resident #26's hyponatremia was a recent problem. RD P said she was aware Resident #26's g-tube would become clogged because the nurses had mentioned it to her in the last month or so. RD P said in general nurses did not notify her or the doctor of additional water given to de-clog the g-tube because it was a negligible amount (so small, not worth considering). RD P said she did not believe Resident #26's g-tube was becoming clogged every day, because it would be documented by the nurses and they would need to notify the doctor too. RD P said Resident #26 was on a water restriction and he was getting 1200mL of water. She said that volume consisted of the water provided by the enteral feedings and free water because that's all that I can be sure of. RD P said the water that was given with medication passes or to de-clog the g-tube were not tracked, and not included in the 1200mL total she calculated, but the doctor was aware of it. RD P said she expected nurses to follow enteral feedings orders and not following orders definitely needs to be corrected. RD P said she was not notified of each lab and NP K also communicated with nephrology as well. RD P said his sodium level was still lower than we consider normal but for him it's ok. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/19/22 at 9:49 AM, MD L said the effects prolonged hyponatremia depended on the nature of the hyponatremia such as if it was related to heart failure or fluids overload. MD L said symptoms hyponatremia included fluid overloaded, too puffy, falls, dizziness, and cognitive decline. MD L said Resident #26 was dialysis, regardless of g-tube, the hyponatremia should be corrected by dialysis. MD L said they needed to make sure the g-tube feeding was made for renal patients, but if Resident #26 was dialyzed 3 times a week, the renal machine should correct the hyponatremia. MD L said that was the responsibility of the dialysis unit, to make sure that by the end of dialysis the electrolyte imbalance was corrected. MD L said if the resident remained hyponatremic, there was a huge question in my mind of the quality of his dialysis. He said the nephrologist needed to be questioned because they should have corrected the electrolyte issues. Review of the facility policy titled, Enteral Nutrition, dated 08/01/12 reflected the policy did not address positioning during enteral feedings or monitoring of feeding pumps to ensure feedings were given as ordered. The policy also did not address enteral feedings for residents on dialysis or on fluid restrictions. Review of the facility policy, Medication Administration through an Enteral Tube, dated 10/31/16, reflected the following: . Place resident in proper position with head of bed elevated to 45 degrees . Restart the enteral feeding as ordered . According to the website https://www.merckmanuals.com/professional/endocrine-and-metabolic-disorders/electrolyte-disorders/hyponatremia, accessed on 03/25/22 reflected, . Hyponatremia is decrease in serum sodium concentration < 136 mEq/L (< 136 mmol/L) caused by an excess of water relative to solute. Common causes include diuretic use, diarrhea, heart failure, liver disease, renal disease, and the syndrome of inappropriate antidiuretic hormone secretion (SIADH). Clinical manifestations are primarily neurologic (due to an osmotic shift of water into brain cells causing edema), especially in acute hyponatremia, and include headache, confusion, and stupor; seizures and coma may occur. Diagnosis is by measuring serum sodium. Serum and urine electrolytes and osmolality and assessment of volume status help determine the cause. Treatment involves restricting water intake and promoting water loss, replacing any sodium deficit, and correcting the underlying disorder. An observation of Resident #26 feeding pump setting revealed it was set to administer Nepro 1.8 with Carb Steady at 50mL/hr and water flush was set to 20mL/hr. Review of training records reflected on 03/17/22, nurses received an in-service titled G-tube, Pump calibration for enteral feeding and free water. In an interview on 03/19/22 at 9:49 AM, MD L stated he was called by the interim ADM (ADM B) yesterday, 03/18/22, and they reviewed two different IJs, one included hyponatremia. In an interview on 03/19/22 at 12:42 PM, the DON said with Resident #26 being in and out of the hospital, the orders could change. She said nurses needed to make sure the order corresponds to the settings of the pump and the feeding and water are labeled. The DON said for residents who were on dialysis, nurses should follow the prescribed water flush and any extra water given should be documented so that the provider and RD could take account of it. The DON said she expected nurses to include documentation on the measures implemented whenever the g-tube is clogged. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/19/22 at 1:31 PM, LVN D said she was also the DCC and at times would work the floor when needed. LVN D said she received training on g-tubes. LVN D said residents with g-tubes should have an order in the system that specifies the rate of feeding and water flush. LVN D said the feeding pump settings should be compared to the order during the first rounds, when a nurse arrives for his/her shift so they could ensure the resident received the right amount of feeding and water or they could get dehydrated or cause hyponatremia. LVN D said signs of hyponatremia included confusion, poor skin turgor, or flushed skin. LVN D said residents with ESRD were unable to produce any output so they had to be dialyzed or they could go into fluid overload. LVN D said signs of fluid overload included signs of congestive heart failure, tachycardia, or heart issues. In an interview on 03/19/22 at 1:48 PM LVN J said she worked PRN and worked the 2PM to 10PM shift on weekdays and weekends. She said received training on g-tubes. She said she was trained before hanging a feeding she should label the feeding with resident name, rate, date, and time it started, and the water bag must include all that information as well. LVN J said before a feeding is started, a nurse should review what is ordered corresponds to the pump settings. The nurse said it was very important because if the nurse does not follow the enteral order it may result in fluid overload or dehydration and cause a lot of complications. LVN J said residents with ESRD retain fluids and that caused a lot of complications such as cardiac or kidney complications. LVN J said they were on strict fluid intake. LVN J said signs of hyponatremia included change in blood pressure, swelling, cardiac overworked and then a cardiac complication, or difficulty breathing In an interview on 03/19/22 at 2:06 PM, the DCO said audits for enteral feedings were in place. She said the DON or designee was to complete the audits every day and review them in the daily morning clinical meetings. The DCO said she would review the audits weekly. In an interview on 03/19/22 at 2:11 PM, LVN F said he worked the 10PM to 6AM shift. He said he received training on g-tubes and whatever we hang has to match what is in the system. The order should match. Feeding set up needs to be changed every 24 hours. LVN F said when arriving for their shift and completing initial rounds, nurses should check feeding pump set up, check the formula, check the pump settings and amounts the patient receives per hour. LVN F said it was very important to verify order or the resident could receive too much or too low fluids. the order. He said signs of hyponatremia included change in breathing, crackles, lethargy, weakness, decreased response, not acting like themselves, or a slow response. In an interview on 3/19/2022 at 1:37 PM, ADM B stated she will monitor the auditing tools in place and continuing education during our clinical start-up Monday through Friday for corrective actions. She stated she will then take the audits and put on her master audit log to ensure compliance. She also stated would be discussed in QAPI each month until resolution. In an interview on 03/19/22 at 2:26 PM LVN G said she worked the 2PM to 10PM shift. She said she received training on g-tubes and making sure the order matches the setting on pump when nurses come on shift and did our rounds. LVN G said it was important to make sure pump setting were correct because if residents were given too many fluids it could cause nausea or vomiting. She said for residents with ESRD, they kidneys could not get rid of the excess water and they could have fluid overload. LVN G said signs of hyponatremia included weakness, fatigue, nausea, vomiting, or confusion. Review of Resident #33's MDS Assessment, dated 01/26/22, reflected she was admitted to the facility on [DATE]. Her diagnoses included dysphagia. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #33's orders in the electronic health record on 03/15/22 reflected the following orders: TF ORDERS: Glucerna 1.5, 55 mL per hour for 22 hours daily via g-tube and free water 70mL per hour for 22 hours via g-tube. Review of Resident #33's care plans, dated 03/16/22, reflected Resident #33 required tube feeding due to dysphagia. Interventions included the resident needed the head of bed elevated 45 degrees during and thirty minutes after tube feeding. An observation on 03/15/22 at 9:50 AM revealed CNA N and the RC were in Resident #33's room providing care. CNA N lowered the head of the bed flat, and the tube feeding was still running into the resident's g-tube. After completing incontinent care, CNA N raised the head of the bed. In an interview on 03/15/22 at 10:06 AM, the RC said CNA N had lowered the head of the bed and she had not noticed Resident #33's tube feeding was still running. The RC said she was also a CNA and said Resident #33' bed should not have been flat, and the nurse should have been notified so she could turn off the feed. The RC said residents with feeding tubes should not be laid flat while their feeding was running, because they could aspirate. In an interview on 03/15/22 at 12:19 PM, CNA N said normally the nurse would place Resident #33's tube feeding on hold or turn it off. CNA N said she notified RN O she was going to be providing incontinent care for Resident #33 and thought RN O had already placed the feeding on hold. CNA N said she did not notice the feeding was still infusing and tube feedings should be held if a resident's bed is lowered or they could aspirate. In an interview with RN O on 03/15/22 at 12:29 PM, she said she instructed CNA N to complete incontinent care on Resident #33, but she was not aware when CNA N went in the resident's room. RN O said that was the reason she did not place Resident #33's tube feeding pump on hold. RN O stated the tube feeding should be held when providing incontinent care because when the resident's head of bed was lowered, the resident could vomit and aspirate the vomit into their lungs. In an interview on 03/19/22 at 12:42 PM, the DON said she expected the CNA to notify the nurse when they would complete incontinent care for a resident with a tube feeding so the nurse could place the feeding on hold. She said there was a risk for aspiration if the feeding was not held and the head of bed was lowered. Review of the facility policy titled, Enteral Nutrition, dated 08/01/1,2 reflected the policy did not address positioning during enteral feedings or monitoring of feeding pumps to ensure feedings were given as ordered. Review of the facility policy, Medication Administration through an Enteral Tube, dated 10/31/16, reflected the following: . Place resident in proper position with head of bed elevated to 45 degrees . Restart the enteral feeding as ordered

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42627 Based on observation, interview, and record review the facility failed to ensure that prior to the installation of bed rails, the resident was accurately assessed for the use of bed rails, which includes a review of risks including entrapment, reviewing the risks and benefits of bed rails with the resident and obtaining informed consent from the resident for 1 (Resident #33) of 5 residents reviewed for bed rails. The facility failed to accurately complete Resident #33 bed rail assessment and failed to identify the resident could not use the assist bars on her bed and she wanted them removed. This failure placed residents at risk of injury related to bed rails or assist bars. Findings included: Review of Resident #33's face sheet, dated 03/16/22, reflected she was a [AGE] year-old female and she was her own RP. Review of Resident #33's MDS assessment dated [DATE] reflected she was admitted to the facility on [DATE]. Her diagnoses included: diabetes mellitus, spastic hemiplegia (paralysis affecting one side of the body) affecting right and left side, and convulsions. Review of Resident #33's care plans, dated 03/16/22, reflected In an observation on 03/15/22 at 9:50 AM, revealed CNA N and the RC were providing Resident #33 with incontinent care. After care was provided, Resident #33 was positioned on her back and there were 1/8th assist bars engaged on the left and right sides of the bed. Resident #33 had a trach and could not verbalize answers but could nod to indicate yes and no. In an observation on 03/16/22 at 7:03 AM, Resident #33 was lying on bed on her back. She was resting with her eyes closed. There were assist bars engaged on the left and right sides of the bed. Review of Resident #33's orders on the electronic health record reflected Resident #33 had an order for: RESIDENT MAY USE U-RAILS/SIDE RAILS FOR REPOSITIONING, BED MOBILITY, AND SAFETY. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, observation, and record review on 03/18/22 at 1:21 PM, the DON said Resident #33 was her own RP. The DON said Resident #33 did not move and the assist bars on her bed were not for safety. The DON said the order for Resident #33's side rails were incorrect, because they were not for REPOSITIONING, BED MOBILITY, or SAFETY. The DON and HHSC surveyor reviewed the bed rails assessment and consent for Resident #33 which was completed on 05/21/21. The DON stated the bed rails assessment incorrectly assessed Resident #33 as being capable of using the call light to request assistance and identified Resident #33 as currently using the side rail for positioning or support. The DON also stated if Resident #33 gave consent for the side rail, her name should have been listed on the consent. During an observation of Resident #33 the DON revealed Resident #33 indicated she did not use the side rails, she did not like the side rails, and she wanted the side rails removed. In an interview on 03/19/22 at 2:06 PM, the RDCO stated the facility did not have a policy on side rails.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Tag: F-740 S/S= G-1 Based on observation, interview, and record review the facility failed to ensure each resident received the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 1 of 16 residents (Resident #5) whose records were reviewed for behavioral health services, in that. The facility failed to ensure Resident #5 received behavior health services including interventions for behavior disturbance and diagnosis of schizophrenia, and major depressive disorder. This failure could place residents at risk for not a significant change emotionally and psychologically, and prevent him from reaching his highest practicable physical, mental, psychosocial well-being, therefore affecting his quality of life. Review of Resident #5's face sheet dated March 17, 2022, revealed a [AGE] year-old male admitted to the facility on 01/26/2022. Resident #5's diagnoses included Burn of second degree of right foot, Initial encounter 01/26/2022, Principal Diagnosis (#67) Admitting Dx (#69) Anemia, Hyperlipidemia, Coagulation Defect, Schizoaffective Disorder, Unspecified, Major Depressive Disorder, Recurrent, Unspecified. A record review of Resident #5's quarterly MDS dated [DATE] did not reveal an assessment section completed to address the resident's frequencies of mood. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident #5's current physician orders dated 03/16/2022, revealed that he has been prescribed, Risperdal 2mg for Schizophrenia, Zyprexa 10 mg for Schizophrenia, Olanzapine 5mg antipsychotic, Zoloft 50 mg for anxiety and depression, and Simvastatin 40mg Hyperlipidemia. The facility had documentation of the resident 's non- compliance and refusal of medication. A record review of Resident #5's February 2022 and March 2022 MAR revealed no side effects with use of antidepressant and antipsychotic medications. A record review of Resident #5's care plan revised on March 15, 2022, revealed that Resident has frequent behaviors which include Tearing things up, slamming doors, hitting and breaking bedside table in his room, and breaking the dresser drawers. Prefers female to attend to him. Interventions include Administering medications as ordered, monitor and document side effects and effectiveness, anticipate and meet the resident's needs, caregivers provide opportunities for positive interactions, attention, and acknowledging resident through communicating in passing. When appropriate discuss the behaviors demonstrated by the resident and explain the importance of communicating to staff and taking his medication to stop the voices in his head. Staff must always reinforce appropriate behaviors for resident to exhibit. Caregivers will provide positive praise for appropriate behaviors and keep resident away from other residents when angry; Give medications according to the doctor's orders; Assist the resident with locating a favorite place to go and calm down; Offer the resident something that he enjoys to distract the maladaptive behaviors. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Interventions to address the resident's Major Depressive Disorder include adhering to his medication regimen by taking his prescribed medication on time, as well as monitor and report concerns to the physician. An observation and interview March 15, 2022 at at 10:19 a.m. revealed Resident #5 walking down the Hall 200 west very fast and brisk. He appeared to be angry. He turned around and returned to his room, cursing very loud, slamming the bathroom door very hard. His behaviors were very concerning, however when staff were asked how they were trained to intervene and redirect, the response was to ignore the behaviors or redirect to his room. The concern with redirecting the resident to his room, led to him disturbing the other residents on the hall by continuous yelling, banging, slamming of doors, and destructing property at the facility. An observation and interview on March 15, 2022 at 1:19 p.m. Resident #5 was observed sitting quietly with his mask on downstairs in the lobby across from the receptions desk. An observation and interview March 15, 2022 at 2:30 p.m. Resident #5 was observed walking fast down the 1st floor hall toward the receptionist desk very fast, appearing angry. When approached, he stated that he was leaving going to the hospital. In an observation of resident #5's room on March 16, 2022, it revealed that all his personal items were gone, and his side of the room was vacant. In an interview with LVN B, revealed that Resident #5 was sent to the hospital on March 15, 2022 at 3:15 PM for psych observation. She did not know if the hospitalization was voluntary or involuntary. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	An interview on March 16, 2022 at 12:19 p.m. with SW revealed that Resident #5 refused a psychiatric medication several times today. He stated that the resident will often tell him that he hears voices in his head. He has offered resident therapy to assist with processing his feelings and deal with the anger, but the resident refuses services. SW stated that the resident does not understand the importance of taking his medication, and he was very disruptive and loud when other residents are trying to sleep. SW stated that the resident has exhibited verbally aggression toward staff, when approached to take his medication. SW stated that he has tried to redirect resident and encourage compliance with medication, however he has not been successful. SW stated that he has been pursuing a behavior facility that is better equipped to meet the behavior needs of the resident #5. In a Record Review dated March 15, 2022, revealed a behavior outburst of defiance and aggression at 7:36 am. The staff called 911 when the resident became aggressive with hopes of him receiving treatment at a hospital setting. Once law enforcement and EMT arrived, resident #5 was calm sitting on the couch downstairs. Law Enforcement encouraged him to take his medication and EMT's assessed him for Homicidal or Suicidal behaviors. Resident#5 resumed the loud disruptive behaviors inclusive of slamming doors, using profanity, and racial slurs toward the staff. A record review of a progress notes by LVN-F read, that she had crushed resident medication up in his food without him knowing to give his medication after he refused. In a review of Resident #5's physician orders and MAR, revealed that there were no orders to crush the resident's medications. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Interview with Primary Care Practitioner March 17, 2022 at 2:30 p.m., revealed that he was unsure if had given the facility an order to crush medications and mix them with food for Resident #5. He stated that if it's not a time- released medication then he wouldn't have a problem with the nurse crushing medications and mixing them the in food. He stated that he would still expect the nurse to follow standards of care with gaining consent from the resident. In an interview with the Psychiatrist on March 17, 2022 at 3:12 pm, revealed that that he prescribed resident #5 50mg of Zoloft for anxiety and depression every morning on February 9, 2022, however upon looking at Resident #5s MAR, there were not medications orders listed for Zoloft, and this was communicated to the doctor. The stated that he had not discontinued the Zoloft, and it could have possibly addressed the depression and anxiety that resident #5 was experiencing. The Dr. stated that on March 16, 2022, he increased resident #5's Zyprexa, as well as prescribed him Risperdal for insomnia and aggressive behaviors. In the event this medication is effective, he will prescribe the Risperdal injections that would address the medication refusal and treat the psychotic episodes. He stated that it would be acceptable to crush up Resident #5's medications, as it is more important for him to take his medication than be concerned with staff administering without consent. He stated that the SW was seeking a behavior facility. The facility reported to the Dr. that Resident #5 was hospitalized after destroying property, however, the hospital released resident as he was not in any imminent danger. Dr. stated that the Nursing facility was equipped to provide the level of care and supervision that resident #5 needs. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	A record review of the progress notes on March 17, 2022 at 4:06 p.m. revealed that the SW had located and has initiated intake at Well-Bridge Behavioral for Resident #5's. The facility can meet the therapeutic needs of the resident. When the social worker was asked to provide documentation of the psychiatrist consult with resident #5 on 3/18/2022, he returned and stated that he had not received the written report, however he does have the psychiatric review from February 9, 2022. A review of the psychiatric records dated February 9, 2022, revealed that the facility received the medication order via fax transmittal on February 14, 2022. The document revealed that the Dr had prescribed Zoloft 50 mg for resident #5 to treat his anxiety. In an interview of LVN-F on 3/17/2022 at 5:00 PM, revealed, that she had been told by a medication Aide to crush the resident's food in his food if he refused the medication. She has crushed his medication without his knowledge for on two occasions. He did not eat the food the second time. She stated that she did not observe a physician order to crush the resident #5s medication. When LVN-F was asked if she had received a telephone order from the Dr. on February 9, 2022 to start Zoloft for resident #5; she denied that an order was given via phone, however the Dr. submitted an order by phone to increase his Zyprexa. In an interview on March 18, 2022 at 9:00 am with LVN-G, revealed that Resident #5 does exhibit aggressive behaviors toward staff, and his behaviors have increased, along with his paranoia. She does not have concerns for the safety of the resident's, as he has been gentle and caring toward residents. She has educated the resident on (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	treatment of his medication and how it could assist with the voices in his head. She stated that she has received several complaints from residents about Resident #5 slamming the doors, yelling, and being very disrupted at night while they are trying to sleep. In an interview on with the DON on March 18, 2022 at 10:12 a.m. revealed that she had received consent from resident #5 to crush his medication in pudding, as this was how her preferred medication administration. She stated that resident #5 refused counseling. She stated that they have a standing medication order from the Dr. to crush medication. The DON reviewed records and medication orders for resident #5, and she was unable to locate standing crush orders. She stated that the nurses would be responsible for transcribing the phone orders from the doctor, and the orders were faxed to the facility later. She was not aware that the order for Zoloft had been submitted nor had she viewed the order from February 9, 2022. An interview on March 18, 2022 3:20 PM with resident #5, revealed that he would like to take his meds, Crushed up in pudding. Resident #5 stated that it is difficult for him to swallow a whole pill I couldn't take it. He stated that he prefers his medication in pudding, and he was aware that the staff were crushing medication in his pudding, and he has given consent. In a review of the facility policy titled Resident Rights and quality of life, revealed that all residents have the right to a dignified existence, self-determination, and communication with an access a to people and services inside and outside (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	of the facility. A resident has the right: To exercise his/her rights as a resident of a facility and a citizen or resident of the U.S. and be free of interference, coercion, discrimination, or reprisal by its employees. To be fully informed of his/her rights and all rules and regulations governing the resident conduct and responsibilities during the stay in the facility. To refuse Treatment. To be free of physical restraints imposed for the purpose of discipline or convenience and not required to treat medical symptoms. Iidentifiers: DX-Diagnosis EMT-Emergency Medical Team PCP-Primary Care Physican mg-milligrams U.S.-United States

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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 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. 42627 Based on interviews, observations, and record reviews, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 1 (First Floor East Hall Medication Cart) of 3 medication carts audited for controlled substance security and records. The facility failed to ensure RN C did not inaccurately document and sign out a hydrocodone tablet as wasted. This failure placed all residents who received controlled substances at risk for an inaccurate record of their medications and potential drug diversion. Findings Included: An observation on 03/16/22 at 6:31 AM revealed LVN H and RN C were standing at the First Floor East Hall Medication Cart. LVN H was counting the medications in the narcotic drawer while LVN H verified the count on the controlled substance forms. LVN H said Resident #67's hydrocodone-acetaminophen 10mg-325mg tablet count was 8 and she looked at the control drug record and said that count said 7. RN C then said she had miscounted earlier and had only seen 7, so she signed one tablet out as wasted. Further observation revealed there were 8 hydrocodone-acetaminophen 10mg-325mg tablets in the pill pack. Record review of Resident #67's hydrocodone-acetaminophen 10mg-325mg tablet control drug record reflected on 03/16/22 at 4 AM 1 tablet was wasted and signed as witnessed by RN C and LVN K. The count of available tablets was documented as 7. In an interview on 03/16/22 at 7:45 AM, RN C said 1 tablet for Resident #67 was not wasted. RN C said she had signed the tablet out before giving it and when she realized it was too early to give Resident #67 the medication, she documented it was wasted. She said she made an error and she should have struck through the documentation signing out the medication, and she should not have documented the medication was wasted. In an interview with the DON on 03/16/22 at 7:22 AM, she said RN C made an error in documenting the hydrocodone tablet as wasted. She stated it was her expectation two nurses would visually verify a controlled medication was wasted prior to signing the record as wasted. The DON said the second nurse who signed out the medication as wasted was RN C's trainee. The DON said the trainee probably thought RN C was correct in signing out the medication as wasted, but RN C was wrong. The DON stated she would re-train the nurses on the correct procedure for wasting controlled medications. Review of the facility policy titled Inventory Control of Controlled Substances, dated 12/01/07, reflected the policy did not address wasting controlled substances.