STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675229	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing and Rehabilitation	99 Rigby Owen Rd Conroe, TX 77304

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 Based on interview and record review the facility failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for two of seven residents reviewed (Resident #1 and Resident #2) for ADL care. 1. The facility failed to ensure Resident #1 was provided timely incontinent care and a full shower. 2. The facility failed to ensure Resident #2 was provided timely incontinent care and a shower. These failures could place residents at risk of not having personal care needs met which could cause pain, skin breakdown and low self-esteem. Findings included: 1. Record review of Resident #1's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses which included pressure ulcer (skin break down) of right buttock; stage 3, pressure ulcer (skin break down) of left buttock; stage 3, muscle weakness, urinary tract infection (infection in any part of the urinary system), chronic kidney disease, type 2 diabetes, pain, edema (swelling by excess fluid) and diarrhea. Record review of Resident #1's, undated, care plan revealed the resident had urinary incontinence and staff were to check for incontinence every 2 hours. Resident #1 was care planned for limited assistance for bathing/hygiene, dressing/grooming and toileting. Resident care should be provided per facility protocol. Resident #1's preferred bath time was T-TH-Sat from 6 PM to 6 AM shift. Record review of Resident #1's Comprehensive MDS, dated [DATE], revealed the resident had a BIMS of 15, which indicated Resident #1 was cognitively intact. Resident #1 required one person physical assist for toileting required physical assist by one person for bathing. Record review Resident #1's ADL Category Report revealed Resident #1 did not receive a bath on Saturday, 10/30/21, Tuesday, 11/2/21. Resident #1 received a bed bath on Thursday, 11/4/21. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/5/21 at 11:07 a.m. with Resident #1, she said she was admitted in August 2021. She said when she needed to be changed, she had to wait a long time. She said she was left soiled in feces and urine. She said she was wet and pushed her call light around 9 AM this morning, and she was told by CNA A there were other residents in front of her and they would get to her when they get to her. She said she still was not changed. She said she has not received a full shower. In an interview on 11/5/21 at 11:12 a.m., CNA A said Resident #1 had not been changed this morning. She said she was just now getting to her, and her shift started at 6 AM. She said the policy was to change every 2 hours or more often if needed. She said she was the only CNA for 37 residents. CNA A stated Resident #1 was wet. In an interview on 11/5/21 at 9:15 p.m. with Resident #1 she said she was wet, and her bottom was sore and it hurt. She said she had not been changed since the day shift CNA A left and her shift ended at 6 PM today. She said the last time she was changed was before 6 PM. She said she had not had a bath all week. She has been told there was not enough workers. In an interview on 11/5/21 at 9:30 p.m. with CNA B, he said he did not change Resident #1. He said when the evening staff came on duty at 6PM, they first have to take care of the evening dinner trays, so residents do not get changed until after that. He said he would change Resident #1 now. He said baths were given later in the evening after rounds, usually around 11 PM. He said baths were marked on the ADL care documentation. He said incontinent care should be done every 2 hours but it did not always happen because of staffing issues. He said residents did not receive showers as scheduled because there were not enough staff. In an interview on 11/5/21 at 10:15 p.m. with CNA D, revealed there was a bath schedule but the bath schedule did not match the resident's schedule. The resident's ADL chart would say the resident should a have a bath on a Tuesday morning, but the hall chart indicated a different time. This could be a reason residents don't get bathed because staff follow different schedules. 2. Record review of Resident #2's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 had diagnoses which included abnormalities of gait and mobility, local infection of the skin and subcutaneous tissue, seborrheic dermatitis (skin condition causing scaly patches), muscle weakness, muscle wasting and atrophy, bacterial infection, pain and open wound left knee. Record review of Resident #2's Minimum Data Set, dated dated [DATE], revealed the resident had a BIMS of 15, which indicated she was cognitively intact. The MDS revealed Resident #2 required extensive assistance by one person assist for toileting and bathing. Record review of Resident #2's, undated, care plan revealed Resident #2 was care planned for incontinence starting 10/12/21. Interventions included check for incontinent every 2 hours and as needed. Resident #2 was care planned for ADL care starting 10/12/21. Interventions included resident required extensive assistance with bathing and toileting. Record review of the ADL Category Report revealed Resident #2 had not received a bath from 10/30/21 through 11/5/21. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/5/21 at 11:57 a.m., Resident #2 said she had not had a bath this week. She said her family member had to bathe her because the facility did not. She said it was reported to the administrator through a grievance. In an interview on 11/5/21 at 10:30 p.m., Resident #2 said she had to have a bowel movement, but staff did not come back to assist her to the toilet. She said she couldn't walk and the bed pan she usually used, was missing in her room. She said she notified staff about 20 minutes ago and no one came back. She said staff told her they could not find the bed pan and did not know what to do. She said she could not hold it too much longer. In an interview on 11/5/21 at 10:40 p.m., CNA D said she could not find the bed pan. She said she might be able to help Resident #2 walk to the toilet but she was not capable of putting any weight on her feet. She said she would go find something. Observation on 11/5/21 at 10:50 p.m. was CNA D returned with a bed side toilet. In an interview on 11/9/21 at 12:00 p.m. Resident #2 said last night (11/8/21), she had to sleep in BM because her bed pan still had not returned, and she had no beside commode. The Staff did not come to help her. She said she was embarrassed and had no dignity but could not afford to go anywhere else. She was cleaned up this morning when a staff person came to get her to dialysis. She did not remember the staff on duty or the time frame. In an interview on 11/9/21 at 1:13 p.m. with Resident #2's representative party, she said CNA A reported to her she found her in BM this morning. She said the facility did not bathe her for weeks, she had to bathe her when she went to visit. In an interview on 11/5/21 at 11:00 p.m. with the Administrator, he said showers late at night were given at 10 PM or 11 PM was not acceptable because many residents are sleeping at this time. He said he was unaware staff attempted to give showers so late. He said he was unaware why residents have gone a week without a proper bath. He said his expectation was to follow the residents shower schedule and have showers done at a reasonable time, after dinner or before bedtime in the evening. He said his expectation was for incontinent care to be provided every 2 hours or more depending on the resident's need. He said the lack of showers and lack of frequent incontinent care placed residents at risk of skin break down, UTI's, and other infections. In an interview on 11/12/21 at 10:20 a.m. with DON B, she said if Resident #1 was not changed timely and frequently she was at risk of being septic due to already having open wounds to her sacral area. She said all residents are at risk of skin breakdown, infections, and possibly falls if residents try to get up on their own to use the restroom. She said residents were at risk of skin break down and infections if residents were not being showered appropriately. Record review of the facility's policy Activities of Daily Living Policy, dated March 2018, revealed residents who were unable to carry out ADLs independently will receive the services necessary to maintain .grooming, and personal and oral hygiene. Residents will receive services in accordance with the plan of care with hygiene (bathing), and elimination (toileting).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 Based on observation, interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and residents' choices for 1 residents of seven residents reviewed (Resident #2) for quality of care. 1. The facility failed to ensure Resident #2 received wound treatment daily. This failure could place residents at risk of not receiving medical services necessary to maintain the highest practical well-being. Findings included: 1. Record review of Resident #2's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 had diagnoses which included polyneuropathy (malfunction of peripheral nerves), gangrene (dead tissue), local infection of the skin and subcutaneous tissue, seborrheic dermatitis (scaly patches on skin), muscle weakness, muscle wasting and atrophy, pain and open wound left knee. Record review of Resident #2's, undated, care plan revealed the resident was care planned for pressure ulcers. Interventions included follow facility skin care protocol, preventative measures, and treatment as ordered. Record review of Resident #2's Minimum Data Set, dated dated [DATE], revealed the resident had a BIMS of 15, which indicated the resident was cognitively intact. Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed the wound specialist to evaluate and treat once a day on Monday 6 AM to 6 PM. Record review of November 2021 Medication Administration report revealed the physician order for the wound specialist to evaluate and treat once a day on Monday 6 AM to 6 PM did not occur on Monday, November 1, 2021. Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed on the left dorsal foot ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed the physician order for the left dorsal foot ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM, did not occur on November 3rd, 6th, 7th, 8th and 9th. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Physician order Report, dated 10/12/21 through 11/12/21, revealed on the left great toe ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed the physician order for the left great toe ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM., did not occur on November 3rd, 6th, 7th, 8th and 9th. Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed on left medial thigh Calciphylaxis: remove old dressing, cleanse with Acetic acid 0.25% 5 minute soak, rinse with NS, cleanse the peri-calciphylaxis area with soap and water, use santyl or medihoney as the primary dressing, use ABD pad, adaptic, hypafix tape, kerlix, mepilex-bordered and moistened, saline gauze cut to fit wound as the secondary dressing once a day, 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed that the physician order for left medial thigh Calciphylaxis: remove old dressing, cleanse with Acetic acid 0.25% 5 minute soak, rinse with NS, cleanse the peri-calciphylaxis area with soap and water, use santyl or medihoney as the primary dressing, use ABD pad, adaptic, hypafix tape, kerlix, mepilex-bordered and moistened, saline gauze cut to fit wound as the secondary dressing once a day, 6pm to 6am, did not occur on November 3rd, 6th, 7th, 8th and 9th. Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed on left posterior calf Calciphylaxis: remove old dressing, cleanse with Acetic acid 0.25% 5 minute soak, rinse with NS, cleanse the peri-calciphylaxis area with soap and water, use santyl or medihoney as the primary dressing, use ABD pad, adaptic, hypafix tape and kerlix, as the secondary dressing once a day, 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed the physician order for left posterior calf Calciphylaxis: remove old dressing, cleanse with Acetic acid 0.25% 5 minute soak, rinse with NS, cleanse the peri-calciphylaxis area with soap and water, use santyl or medihoney as the primary dressing, use ABD pad, adaptic, hypafix tape and kerlix, as the secondary dressing once a day, 6 PM to 6 AM., did not occur on November 3rd, 6th, 7th, 8th and 9th. Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed on the left second toe ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed the physician order for the left second toe ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6pm to 6am., did not occur on November 3rd, 6th, 7th, 8th and 9th. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed on the right great toe ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed the physician order for the right great toe ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM, did not occur on November 3rd, 6th, 7th, 8th and 9th. Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed on right knee Calciphylaxis: cleanse with Acetic acid 0.25% 5 minute soak, rinse with NS, cleanse the peri-calciphylaxis area with soap and water, use santyl or medihoney as the primary dressing, use 2x2 gauze, adaptic, hypafix tape and kerlix, as the secondary dressing once a day, 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed the physician order for right knee Calciphylaxis: cleanse with Acetic acid 0.25% 5 minute soak, rinse with NS, cleanse the peri-calciphylaxis area with soap and water, use santyl or medihoney as the primary dressing, use 2x2 gauze, adaptic, hypafix tape and kerlix, as the secondary dressing once a day, 6 PM to 6 AM, did not occur on November 3rd, 6th, 7th, 8th and 9th. Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed on the right lateral foot: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed the physician order for the right lateral foot: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM, did not occur on November 3rd, 6th, 7th, 8th and 9th. Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed on the right medial ankle ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed the physician order for the right medial ankle ulcer: remove old dressing cleanse with NS, cleanse the peri-ulcer area with soap and water, use betadine paint as the primary dressing, use 2x2 gauze, hypafix tape and kerlix as the secondary dressing once a day from 6 PM to 6 AM, did not occur on November 3rd, 6th, 7th, 8th and 9th. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's physician order report, dated 10/12/21 through 11/12/21, revealed on right medial thigh Calciphylaxis: remove old dressing, cleanse with Acetic acid 0.25% 5 minute soak, rinse with NS, cleanse the peri-calciphylaxis area with soap and water, use santyl or medihoney as the primary dressing, use ABD pad, adaptic, hypafix tape and kerlix, as the secondary dressing once a day, 6 PM to 6 AM. Record review of the November 2021 Medication Administration report revealed the physician order for the right medial thigh Calciphylaxis: remove old dressing, cleanse with Acetic acid 0.25% 5 minute soak, rinse with NS, cleanse the peri-calciphylaxis area with soap and water, use santyl or medihoney as the primary dressing, use ABD pad, adaptic, hypafix tape and kerlix, as the secondary dressing once a day, 6pm to 6am, did not occur on November 3rd, 6th, 7th, 8th and 9th. In an interview on 11/5/21 at 11:47 a.m. with LVN D, he said this was his first day at the facility, he was an agency nurse. He said he was the nurse for Resident #2. He said Resident #2 had multiple wounds, close to 10. They were not pressure wounds. He said the wound dressings were changed about 3 AM or 4 AM this morning. He said he did not need to provide routine wound care as the wound care was done on the night shift. He said he would provide care if the dressing was soiled. In an interview on 11/5/21 at 11:57 a.m. with Resident #2, she said she had close to 12 wounds. She said her dressings were changed at night by LVN C and he was excellent. She said sometimes wound care is not done for a few days. In an interview on 11/5/21 at 8:51 p.m. with LVN C, he said he was the charge nurse. He said he provided wound care every night when he worked, but he could not say what happened when he was not on duty or if anyone provided wound care. He said the wound care doctor went to the facility on ce a week. He said he provided wound care for Resident #2. He said the wounds looked horrible but were healing. He said the resident had a disease that caused wounds. He said Resident #2 required wound care daily and was ordered wound care daily. In an observation and interview on 11/9/21 at 1:13 p.m. with Resident #2, she said she had not received wound care treatment in several days, since November 5th . She said she should receive it daily. Resident #2 said she would receive treatment at weird times of the night, sometimes around 4 AM. Observation revealed Resident #2's dressings on her left and right leg were heavily soiled and almost falling off. The dressings were not dated and didn't have initials. In an interview on 11/9/21 at 1:18 p.m. with Resident #2's representative party, she said she notified DON A about 12:30 p.m. of a needed treatment and dressing change. She said it had been at least 3 days. She said the DON A said she left around 6pm today and she would personally take care it before she left. In an interview on 11/9/21 at 1:30 p.m., with the DON A, she said she was aware Resident #2 needed wound treatment and dressing change. The family notified her and she promised to take care of it before she left at 6 PM today. In an interview on 11/9/21 at 10:04 a.m. with LVN E, she said she was an agency nurse but had worked at the facility for about a year. She said she did not provide routine wound care. She only did wound care as needed if the dressing was soiled. She had not provided wound care for Resident #1 or Resident #2. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/9/21 at 11:43 a.m. with DON A, she said the facility did not have a wound care nurse. It was the responsibility of the nurse assigned on the hallway to complete wound care for assigned hall residents. DON A stated the nurses on the hall were from the agency and they should know their responsibility to provide wound care because she told them. DON A said she would in service the nurses. On 11/12/21 at 10:20 a.m. with the Administrator revealed DON A was no longer at the facility and there was a new DON. He said for Resident #1, if the specific order was not put in system as the doctor prescribed it, then, of course, was an error. He said the responsibility belonged to any nurse. If there was a discrepancy between physician's orders or any confusion, then any nurse should be able to reach out to the doctor for clarification and confirmation to correct the system. He said he wouldn't know why the nurses were not providing wound care. He said his expectation was to provide wound care according to the orders. If the wound care orders changed, then the TAR changed. He said Resident #2 reported not getting wound care treatment because she was asleep at 1 AM or 4 AM in the morning. He said it was her right to sleep. On 11/12/21 at 10:25 a.m, with DON B, she said she was not aware of things happening prior to her. She said wound care treatment should be done according to orders. If not, wounds would not heal and could lead to infections. DON B said wound care should not be done in the middle of the night unless requested by the resident. Record review of the facility's Medication and Treatment Orders policy, dated July 2016, revealed medications shall be administered upon the written order. Record review of the facility's facilities Wound Care Policy, dated October 2010, revealed the purpose was to provide the care of wound to promote healing. The physician's order should be verified and followed.

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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** 41870 Based on observation, interview and record review, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one (Resident #1) of two residents reviewed for pressure ulcers. 1. The facility failed to ensure Resident #1 new orders to apply the zinc oxide cream 3 times daily to stage 3 pressure wounds to left and right buttock were implemented. These failures could place residents with wounds at an increased and unnecessary risk of complications such as pain, acquiring new pressure ulcers, worsening of existing pressure ulcers and infection. Findings included: 1. Record review of Resident #1's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses which included pressure ulcer of right buttock: stage 3, pressure ulcer of left buttock; stage 3, and diarrhea. Record review of Resident #1's, undated, care plan revealed the resident had pressure ulcers due to impaired physical mobility. Interventions required weekly skin assessments and a pressure reducing mattress. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS of 15, which indicated the resident was cognitively intact. The MDS also revealed the resident was admitted with two stage 3 pressure ulcers. Record review of Resident #1's Physician's Order Report, dated 10/12/21 through 11/12/21, revealed an order, dated 10/24/21, to cleanse peri-wound to right and left buttocks daily with WC/NS, pat dry. Apply barrier cream to the peri wound for 30 days. Record review of Resident #1's Physician's Order Report, dated 10/12/21 through 11/12/21, revealed cleanse stage 3 to left buttocks and right buttocks with wound cleanser/NS, pat dry, and apply zinc ointment once daily for 30 days from 6 AM to 6 PM. Record review of Resident #1's Wound Evaluation, dated 10/25/21, completed by Wound Care Physician, revealed the resident had a stage 3 pressure wound to the left buttock, full thickness. The wound size was 10x6x.1 cm. There was no change to wound progression. The resident had a stage 3 pressure wound of the right buttock, full thickness. The wound size was 6x3x.1 cm. There was no change to wound progression. The physician ordered 15% zinc ointment 3 times a day for 23 days. Discontinue house barrier cream. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Wound Evaluation, dated 11/1/21, completed by Wound Care Physician, revealed the resident had a stage 3 pressure wound to the left buttock, full thickness. The wound size was 10x6x.1 cm. There was no change to wound progression. The resident had a stage 3 pressure wound of the right buttock, full thickness. The wound size was 6x3x.1 cm. There was no change to wound progression. The physician ordered the 15% zinc ointment 3 times a day for 16 days. Discontinue house barrier cream. Record review of Resident #1's October and November Treatment Administration did not reflect the new order, dated 10/25, to apply 15% zinc ointment 3 times a day for 23 days. During an observation of incontinent care on 11/9/21 at 10:33 a.m., Resident #1's sacral area was observed to have multiple excoriation on left and right buttocks. Slight bleeding was noted. CNA applied cleansing solution and z-guard cream on wound. Resident #1 was observed with excruciating pain when she was turned. The wound was not dressed. In an interview on 11/5/21 at 11:07 a.m. with Resident #1, she said she had wounds to her bottom. She said as far as she knew she received a barrier cream during incontinent care. In an interview on 11/5/21 at 11:12 am. with CNA A, she said Resident #1 had a large wound to her sacral. She said she applied barrier cream as a preventative measure, but the wound was open and not covered. She said Resident #1 didn't receive daily wound care. She said Resident #1 did not have a bandage on her which was dated . She said she knew resident didn't receive daily wound care because the wound wasn't bandaged. She didn't know why she wasn't receiving wound care. In an interview on 11/5/21 at 11:15 a.m. with LVN B, she said she was the nurse on duty for Resident #1. She said she was not a treatment nurse and she did not provide wound care. She worked through an agency and yesterday was her first day, today was her second day. She said she only had one resident with a wound and it was not Resident #1. In an interview on 11/5/21 at 8:51 p.m. with LVN C, he said he was the charge nurse. He said he provided wound care every night when he worked, but he could not say what happened when he was not on duty. He said the wound care doctor came once a week. He said he was not sure what kind of wound, if any, Resident #1 had. He did not treat her. He said he was not sure who did wound care for Resident #1. It should be whatever nurse was on duty for her hall to provide wound care. He said wound care was split up between the day-time and the night-time nurses. He said he had never done any wound care on Resident #1. In an interview on 11/5/21 at 9:12 p.m. with Woodland Agency LVN, she said she did not provide wound care for Resident #1. She said she just started working at the facility, she was an agency nurse. She said she would not provide wound care for Resident #1. In an interview on 11/9/21 at 10:19 a.m. with Resident #1, she said the wound on her buttocks was very painful. The wound doctor sprayed the wound to numb it during wound care, which helped the pain, but the spray was not used when the wound doctor was not in the facility. The wound doctor went to the facility on ce a week. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/6/21 at 1:10: p.m. with the Wound Care Physician, she said Resident #1 had wounds to her bottom. She said she did not have an apparent infection to her wounds. She had granulation tissue. She said the treatment was for zinc oxide. She said Resident #1 had barrier cream at her bedside. She said there was an order change on 10/25 to increase the frequency of the zinc oxide cream to 3 times a day. Her wounds were worse between the visit of 10/18 ad 10/25. The wound increased in size so she ordered an increase in frequency of the zinc oxide cream to 3 times a day. She said the wounds were noticeable and large, nurses would not be able to ignore them. The wounds didn't necessarily have to keep covered with dressing, but it was important to keep covered with the cream to protect the wounds due to resident being incontinent. She said she was not aware the facility did not follow the new order and apply zinc oxide cream 3 times a day. Not following the order delayed wound healing progress. In an interview on 11/9/21 at 11:43 a.m. with DON A, she said the facility did not have a wound care nurse. It was the responsibility of the nurse assigned on the hallway to complete wound care for assigned hall residents. DON A stated the nurses on the hall were from the agency and they should know their responsibility to provide wound care because she told them. DON A said she would in service the nurses. On 11/12/21 at 10:20 a.m. with the Administrator revealed DON A was no longer at the facility and there was a new DON. He said for Resident #1, if the specific order was not put in system as the doctor prescribed it, then, of course, was an error. He said the responsibility belonged to any nurse. If there was a discrepancy between physician's orders or any confusion, then any nurse should be able to reach out to the doctor for clarification and confirmation to correct the system. He said he wouldn't know why the nurses were not providing wound care. He said his expectation was to provide wound care according to the orders. If the wound care orders changed, then the TAR changed. On 11/12/21 at 10:25 a.m, with DON B, she said she was not aware of things happening prior to her. She said wound care treatment should be done according to orders. If not, wounds would not heal and could lead to infections. DON B said wound care should not be done in the middle of the night unless requested by the resident. Record review of the facility's Medication and Treatment Orders policy, dated July 2016, revealed medications shall be administered upon the written order. Record review of the facility's facilities Wound Care Policy, dated October 2010, revealed the purpose was to provide the care of wound to promote healing. The physician's order should be verified and followed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 7 residents (Resident #3 and Resident #4) reviewed for accidents and supervision. The facility failed to provide adequate supervision to 15 residents in the memory care unit. As a result, Resident #3 was not protected from physical and emotional harm after Resident #4 physically assaulted Resident #3 on two different occasions causing her pain and being afraid to leave her room. An Immediate Jeopardy (IJ) situation was identified on 12/1/2021. While the IJ was removed on 12/6/21, the facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of physical and emotional harm. Findings included: 1. Record review of Resident #3's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident #3 had diagnoses which included anxiety disorder (intense, excessive and persistent worry), Alzheimer's disease (memory loss), osteoporosis (brittle bones), and abnormalities of gait and mobility (unsteady balance while walking). Record review of Resident #3's Comprehensive MDS, dated [DATE], revealed the resident had a BIMS of 2, which indicated a severe cognitive deficit. Resident #3 did not exhibit behavioral symptoms. Resident required supervision and set up or 1 person physical assist for ADLs. Record review of Resident #3's Incident Report for event, dated 10/1/21 at 11:30 p.m., revealed the report was completed on 11/12/21 at 12:43 p.m. by LVN A. The report revealed Resident #3 was hit in her mouth by another resident. This incident occurred in the dining area. Resident #3 was not injured. Record review of Resident #3's Incident Report for event, dated 11/4/21 at 1:50 p.m., revealed the report was completed on 11/5/21 at 11:39 a.m. by RN A. The report revealed Resident #3 was struck in the back of her head by another resident with his hand. Resident #3 stated her scalp was tender. Resident #3 did not have any injury noted around her hair follicles. The incident occurred in the living room. Record review of Resident #3's care plan, dated 10/22/21, revealed Resident #3 resided on the secure unit due to elopement risk. Resident #3 was to be monitored to ensure safety and unit should be kept free of possible hazards. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 11/5/21 at 3:00 p.m. with Resident #3, she said she did not know who it was, but someone came up behind her and hit her in the head. Resident #3 was visibly upset, she was crying. She said she was afraid from being hit. She said she didn't know how staff intervened; she was crying. She said it happened before. She rubbed the back of her head and said it hurt. She said she didn't want to come out of her room because she didn't want to get hit again. In an interview on 11/5/21 at 3:00 p.m. with Resident #3's representative party, she said the facility contacted her in October because Resident #3 was hit in the face. She said she was contacted yesterday (11/4/21) because Resident #3 was hit in the back of the head 4 times. She said the facility reported no injuries both times. She rubbed the back of Resident #3's head and said, there were no bumps. She said Resident #3 said she was hurting. She said she spoke with the administrator today (11/5/21) about the 11/4/21 incident. The administrator could not tell her who the resident was who hit Resident #3, but did tell her both incidents involved the same resident. She said it was reported one of the staff left the unit to get linens yesterday when Resident #4 went up behind Resident #3 and hit her 4 times. She said the one staff on duty had to get help. She said she didn't know what staff were present. She said it was reported to her by the administrator, at the time of the first incident, there was only one staff present in the memory care. She said the administrator told her the plan of action was to always have 2 staff present in the memory care unit. She said she was disappointed and concerned when she came onto the unit and only saw one staff for the day. She said she had been concerned about the staffing. Many times there was only 1 staff in the unit. When there were 2 staff, they just sit in a chair by the door. 2. Record review of Resident #4's face sheet revealed a [AGE] year-old male was readmitted to the facility on [DATE] from local psychiatric hospital. Resident #4 had diagnoses which included dementia with behavioral disturbances (memory loss and symptoms of agitation, depression etc), restlessness and agitation (inner tension), peripheral vascular disease (poor circulation to extremities), syncope and collapse (fainting), and hypertension (high blood pressure). Record review of Resident #4's, undated, care plan revealed the resident had behavioral symptoms of wandering throughout the secure unit. Staff approach was to always ask for help if the resident became abusive/resistive, convey acceptance of resident during periods of inappropriate behavior, redirect as needed. Record review of Resident #4's Quarterly MDS, dated [DATE], revealed the resident was discharged to the hospital on 10/2/21. Resident #4 had a BIMS of 0, which indicated severe cognitive deficit. The MDS reveal ed there were zero behavioral symptoms towards others. Resident #4 required supervision with set up only for ADLs. Record review of the facility investigation, for incident dated 10/1/21 at 11:30 a.m., revealed the Administrator completed the investigation. Resident #4 had a history of physical aggression. There was one staff present at the time of the incident. The incident was described as, the staff was sitting in the living room with the residents watching television when Resident #4 got up and left the room. Staff followed Resident #4. Staff was a few feet away when Resident #4 hit Resident #3 in the face. Staff immediately separated the residents and notified the nurse. No injury was noted. Resident #4 hit Resident #3 without provocation. Resident #4 appeared agitated at the time of the investigation. As a result of the investigation, the Administrator sent Resident #4 to psychiatric hospital for evaluation. No additional actions taken. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the Facility Investigation report, for incident dated 11/4/12 at 11:40 a.m., revealed the Administrator completed the investigation. Resident #4 had a history of aggression. There was one staff present at the time of the incident. The incident was described as, Resident #4 hit Resident #3 in the back of the head in the living room area. At the time of the incident, one of the two staff assigned to the unit had gone to get linens and the other staff was providing care to another resident. As a result of the investigation, the Administrator educated Resident #4 of the right other residents have not to be hit. Staff in-serviced on the need to communicate to ensure there was a staff with residents at the living room area at all times. Staff in-serviced on the policy of not leaving the secured unit unattended. Staff were not in-serviced on any interventions for Resident #4. The investigation report did not include any monitoring of Resident #3 for emotional or physical harm. Record review of Psychiatric Services, Initial Evaluation, dated 11/10/21, revealed Resident #4 was referred due to aggressive behaviors, anger, elopement, long-term and short term memory problems. Resident #4 was admitted to the nursing home from a local behavioral hospital. Resident #4 had a diagnosis of bipolar. Record review of Resident #4's Comprehensive MDS, dated [DATE], revealed Resident #4 did not have any behavioral symptoms towards others. The MDS did not reflect the new diagnosis of bipolar. The MDS reflected antipsychotic medication use. Observation on 11/5/21 at 2:00 p.m. revealed one staff present (CNA E) sitting in the entry way of the living room area in the memory care unit. Staff were not with Resident #4. There was not any other staff on the unit. Observation on 11/5/21 at 2:30 p.m. revealed one staff (CNA E) present on the memory care unit. Observation on 11/5/21 at 3:00 p.m. revealed one staff (CAN E) present on the memory care unit. Observation on 11/9/21 at 10:00 a.m. revealed the Activities Director was one of the 2 staff in the memory care unit. CNA H was the other staff on duty in the unit. Observation on 11/30/21 at 5:25 p.m. revealed 2 staff present in the memory care unit, one staff (CNA J) was in the office on the unit. The second staff (CNA K) was exiting a room down the hall. Resident #4 and Resident #3 were observed in the TV room with 8 other residents, unsupervised. Residents were not visible to either CNA. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 11/5/2021 at 2:20 p.m. with CNA E, she said there were 15 residents in the memory care unit. She said she worked the 6 AM to 6 PM shift. She said she was the only aide in the memory care unit today (11/5/21). She said the assigned nurse comes and goes. She said most of the residents had some type of behaviors. She said she worked yesterday, 11/4/21, at the time of the incident between Resident #3 and Resident #4. She was at the linen closet off the unit when the incident occurred. There was an aide present who was in training, but she could not remember her name. The new aide reported Resident #3 was hit by Resident #4. She said Resident #4 had aggressive behaviors and fought during incontinent care. She said it took 2 people to change him. He was care planned for one person assist in toileting. She said she was able to change him by herself earlier because he didn't fight, but that was not always the case. She said there was not another staff to relieve her to take a lunch, she would go into the office on the memory care unit to eat something. She cannot see the residents in the office while she ate. She said she tried to keep Resident #4 away from Resident #3. She said she had not had any additional training for behavior management, nor had she been instructed with interventions for Resident #4's behavior. She said when she provided incontinent care to residents, there was no one watching the other residents when she was by herself. In an interview on 11/5/21 at 2:34 p.m. with Resident #4, he said people were at war repeatedly. He was not able to answer questions directly. When Resident #4 was asked a question, he repeated people were at war. Interview was in the hallway. Resident #4 was not in sight of CNA E. In an interview on 11/5/21 at 8:45 p.m. with CNA F, she said there were 15 residents in the memory care. She said she worked the 6 PM to 6 AM shift. She said all of the residents had some type of behaviors and that was why they were on the secured unit. She said Resident #4 had behaviors of aggression towards staff and residents. She said she had not been in-serviced on any specific interventions for Resident #4. She said she was not aware on any interventions to protect Resident #3 and Resident #4. She said she just tried to keep them separated. In an interview on 11/5/21 at 8:55 p.m. with CNA G, she said she worked the 6 PM to 6 AM shift. She said she was unaware of any interventions in place to protect Resident #3 from Resident #4. She said she tried to keep them separated. She said he was aware Resident #4 had aggressive behaviors, but was not sure how to handle the aggressive behaviors. In an interview on 11/9/21 at 9:55 a.m. with CNA H, she said she was a temporary employee, and this was her fifth day. She said she worked the day shift, 6 AM to 6 PM. She said there were 15 residents in the memory care unit. She said she was not aware of any resident with specialized supervision or interventions. She said she was informed Resident #4 had behaviors of physical aggression when he needed to be changed. She said she spoke Spanish to him and it generally calmed him down. She said she was not given any specific interventions for his aggression. On 11/4/21, she was changing another resident in the resident's room when she heard someone holler. She said she looked out of the resident's room and another resident said Resident #4 was hitting Resident #3. The incident was in the living room. She said no one had to separate the residents because Resident #4 walked away. She said she did not know the name of the other staff she worked with that day, but she left the unit to go get linens. She said the residents were left by unsupervised because the other staff left the unit, and she was in a resident's room providing incontinent care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 11/9/21 at 10:00 a.m. with the Activities Director, she said she was a CNA and a certified medication technician. She was going through the training to be an activities director. She said the intervention was to remove the aggressor from the area the incident was taking place in and walk the aggressor down the hall to a different area to change the scene. She did not witness either incident between Resident #3 and Resident #4. In an interview on 11/30/21 at 5:25 p.m., CNA J said she was not able to see any residents while she was in the office. She did not know where the other staff were. She said she knew of the behaviors from Resident #4. She said Resident #4 had physical aggressive behaviors towards staff and other residents. She said she was not given any special instruction for Resident #4 and was not aware of special supervision for Resident #4. She said they watched the residents. In an interview on 11/30/21 at 5:30 p.m., CNA K said she knew of the physical aggressive behaviors of Resident #4. She said she could not see any residents while she was in a resident's room. She said she did not know if Resident #4 had any special supervision. She was not given any special instructions. In an interview on 11/30/21 at 1:17 p.m., the MDS Nurse said Resident #4's MDS, dated [DATE], should reflect the behavior on 10/1/21. She said the MDS, dated [DATE], should reflect the new diagnosis of bipolar and the behaviors exhibited on the unit. She said when a psychoactive medication was used for behaviors or diagnosis, the MDS should reflect the diagnosis, medication and behavior. She said the care plan and MDS should correlate. She said she was aware of Resident #4's behavior towards Resident #3. She said Resident #4 was at the psychiatric hospital for about 3 weeks starting 10/2/21. She said she did not change Resident #4's care plan to include any interventions or reflect his aggressive behavior. She said she did not know why she did not, but she should have updated the care plan. She said Resident #4's care plan and MDS needed a change in condition due to the added antipsychotic medication. She said she was the person responsible for implementing interventions. She said she was also responsible for completing the education and updating the staff on the interventions. She conducted in person in-services with the staff when a care plan is updated with new interventions. She said Resident #4's behaviors came on suddenly in October 2021. There were no indications these behaviors were going to start, and likewise, there were no indication the behaviors would stop. Resident #4 was not placed on special supervision. She said she did not update Resident #3's care plan after the incident because she said Resident #3 was not the aggressor. She confirmed that there was not any documentation or assessment completed for the emotional harm Resident #3 sustained or any monitoring of her condition after the incidents. She said to ensure the incidents did not occur again the facility used medications. She said she did not implement specific interventions. She did not complete any in-service with the staff. There were not specific staffing or supervision interventions implemented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 11/12/21 at 10:20 a.m. with the Administrator, he said in the secured unit, memory care unit, there were 2 staff. He said the goal was for one of the staff to always keep an eye on Resident #4. He said at the time of the incident on 11/4, one of the staff left the unit to go get linen and only one staff was left on the unit. He said Resident #4 hit Resident #3. He said in October, the incident occurred, he believed there were 2 staff present. He said Resident #4 had a psychiatric evaluation and was not found to be a danger to himself or others. He said he remembered he had a conversation with Resident #3's representative party and she wanted to know what the facility did to prevent further incidents. He said the measures were to have 2 staff present. He said the intervention was one staff always kept an eye on Resident #4. He said on 11/5/21, he was aware there was only one staff present the entire day shift. He said there was a staffing issue for the facility. He said 2 staff were always scheduled for the unit, but sometimes there were call outs. He said he would go in the unit to supervise residents when there was a need. He said the unit was prioritized, but they did not have back up staff to call and fill the shift. He said they used agency staff when possible, but they do not always get what was needed for staffing. He said he wanted to believe the nurses would get on board as well to assist the unit. He said he completed an in-service on the existing policy. He said the policy did not specify 2 staff needed to be in the unit at all times, but he reminded staff during in-service to not leave the unit without a second staff present. He said the intervention was one staff always kept an eye on Resident #4. He said there was not any documentation of any in service with staff for this intervention. If Resident #4 hit another resident, staff were encouraged to talk to him and redirect the resident to follow the staff away from the resident he had targeted. He said Resident #4 started a psychiatric medication when he was re admitted on ,d+[DATE]. Resident #4 had another episode of aggressive behaviors shortly after on 11/4. There was not any specific intervention in place during the time of monitoring the effectiveness of the medication. Record review of the facility Staffing Requirements of the secured unit, dated 5/13/14, revealed the staffing requirements were determined by the DON. Regardless of the census, if the community required additional staff due to increase incidents/accidents the unit would be staffed to ensure resident safety. The secured unit should not be left unattended, a staff member was required to be present at all times. The policy did not specify the need for 2 staff to be present at all times. This was determined to be an Immediate Jeopardy (IJ) on 12/1/121 at 2:04 p.m. The Administrator and DON were notified. The Administrator was provided with the IJ template on 12/1/21 at 2:04 p.m. The following Plan of Removal was submitted by the Administrator and accepted on 12/2/2 at 5:52 p.m.: Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on December 1, 2021, for failing to protect memory care residents by not providing adequate supervision or intervention to prevent abuse. The Director of nursing and Assistant Director of Nursing will audit all events for aggressive behaviors over 90 days that may have been harmed by December 2, 2021. Any residents identified with aggressive behavior will be offered additional services such as psychological services. The other resident involved in the aggressive incident will be assessed by the Social Worker for emotional distress and the need for additional services by December 2, 2021. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Action: To ensure awareness of other residents who may be exhibiting behaviors towards other residents all direct care staff, nursing management, IDT team, and administrator will be educated on POC documentation of behaviors, ensure CNA communication (To include walking rounds, and nurse to CNA instruction at the beginning of each shift to ensure expectations are met and to review implementation and follow through of care plans. This will be monitored through our daily clinical meeting and widgets identifiers. For any identified resident behavior(s) the interdisciplinary team will initiate an intervention care plan update, provide follow-up documentation to include the effectiveness of intervention change. Completion Timeline: December 1, 2021 and going forward to include staff not working at time of in-service (FT, PT, agency, PRN) Training will be conducted by Regional Nurse Manager. Completed on 12/02/2021. Responsible: Administrator, Director of Nursing, Social Services, Assistant Director of Nursing, and IDT team. 2. Action: Administration conducted education with all direct care staff regarding: 1) Notification upon identification of resident behaviors; 2) One-to-one resident monitoring procedure in which a staff member will be assigned to a resident. (They are not to leave them and must be close enough to intercede in any instance where a behavior could cause harm to another resident, visitor, or staff member), and 3) Dealing with resident behavior to include behavior management and intervention and documenting resident behaviors in POC. Beginning December 1, 2021, direct care staff (agency, PRN, new hires) who have not received the above stated education will be educated by Nursing Administration prior to providing resident direct care. Director of Nursing will be responsible for conducting training. Completion Timeline: Beginning December 1, 2021 and going forward to include staff not working at time of in-service (FT, PT, agency, PRN). Training will be completed 12/02/2021 Responsible: Administrator, Director of Nurses, ADON, CCM, Nurse Manager, Charge nurses 3. Action: Residents with aggressive behaviors will be placed on 1:1 monitoring until alternative placement is found or the resident is no longer a danger to other residents or staff as determined by the IDT team. Direct care staff will be educated on what 1:1 monitoring means. No staff will be assigned to provide 1:1 Monitoring until in-service regarding 1:1 monitoring has been done. As a reminder to the expectation 1:1 supervision tool will be placed in sign in book. Administrator will be responsible to ensure that adequate staffing numbers on the unit are always in place to provide adequate supervision including but not limited to when 1:1 monitoring is being provided. There will be at least two staff members on the secure unit at all times. In the event an employee needs to exit the unit, the employee must contact the charge nurse and wait for relief prior to leaving the unit for break and any other task. If a resident is placed on one on one, there will be three staff in the locked unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Music Therapy: [The facility] will adopt the use of calming music or a resident's favorite type of music as a tool to decrease agitation in a resident. Activities: Woodland Manor will use safe activities as a good way for the resident to get back in touch with their earlier life and find meaning throughout the disease process Socialization: [The facility] will promote more interaction with the residents as much as possible to help decrease agitation in residents with behavior issues. All staff and leadership educated on policies and procedures in identifying at risk residents. All staff in serviced on procedures on policy to promote safety of residents, staff, and visitors. Completion Timeline: December 2, 2021, and going forward to include staff not working at time of in-service (FT, PT, agency, PRN) Responsible: RNM, Administrator, DON, and nurse manager 7. Action: Resident #1 Social Worker will begin working with family and resident for Alternate placement will be sought at one of our more appropriate sister facilities when and if behaviors are controlled and resident is no longer a danger to himself or others. Completion Timeline: December 2, 2021 and going forward to include staff not working at time of in-service (FT, PT, agency, PRN.) Responsible: Administrator, DON, Social Worker Plan of Removal monitoring included the following: Record review was completed for Policies and Procedures which included Identifying Triggers, Identifying Behaviors, Communication between Staff, One to One Observation, Disruptive Behavior, and Not leaving Secure Unattended. Record review of Resident #4's chart included updated care plan and care plan meeting, dated 12/2/21, with RP to discuss behaviors of aggression and additional options for placement at sister facility closer to family. Record review of Resident #3's medical file included an assessment and observations of Resident #3's emotional status and well-being at 3 different times on 12/3/21. Resident #3 was not fearful. Observation and interview of the Resident #3 included resident was out of her room in the TV area. She was talkative to other residents. She stated she was good, happy, and fine. Observations of Resident #4 on different shift, 6 AM to 6 PM, and 6 PM to 6 AM, revealed the resident was on one to one supervision. Resident was not left unsupervised. The secured unit had 3 different staff available on the unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of 6 AM shift change and 6 PM shift change revealed staff could not enter the secured unit without seeing manager on duty, ADON, or DON to receive in-service training. Signs were posted on the front door, and the secure unit as well as at the screening station to notify all staff to see manager on duty before shift. Interviews with 10 CNA's included agency staff, and facility staff, and each shift, 6 AM to 6 PM and 6 PM to 6 AM, revealed each CNA was aware of Resident #4's aggressive behaviors. Each CNA was in-serviced on documenting any behavior in Resident #4's file. Each CNA was trained on Resident #4 receiving one to one supervision. The designated staff assigned to Resident #4 was not available to complete any other tasks related to the unit or other residents. Each CNA stated they were trained to wait for relief from another staff member before leaving the unit or leaving Resident #4's side. Interview on 12/3/21 at 12:53 pm., the Administrator said the facility reached out to the family of Resident #4 about a transfer to a facility closer to the family. The family agreed to the transfer. The facility reached out to a sister facility for transfer. The facilities will review Resident #4's file and determine which facility is a better fit for Resident #4. In the meantime, the facility would maintain one to one supervision for Resident #4. Interview on 12/4/21 at 6:13 p.m., DON B said the signs were placed at the entrance, screening station, and memory care door to ensure if a new agency staff came on board, they would receive the training of behaviors, staffing and one to one supervision before starting their shift. The Administrator and DON were informed the Immediate Jeopardy (IJ) was removed on 12/6/21 at 11:32 a. m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 Based on observation, interview and record review, the facility failed to ensure that staff who provided direct services to residents had the appropriate competencies and skills sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being for 2 of 7 residents (Residents #3 and #4) whose care was reviewed for competent and sufficient staff. The facility failed to ensure there were competent and sufficient staff to supervise 15 residents in the memory care unit. As a result, Resident #3 was not protected from physical and emotional harm after Resident #4 physically assaulted Resident #3 on two different occasions causing her pain and being afraid to leave her room. An Immediate Jeopardy (IJ) situation was identified on 12/1/2021. While the IJ was removed on 12/6/21, the facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of physical and emotional harm. Findings included: 1. Record review of Resident #3's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident #3 had diagnoses which included anxiety disorder (intense, excessive and persistent worry), Alzheimer's disease (memory loss), osteoporosis (brittle bones), and abnormalities of gait and mobility (unsteady balance while walking). Record review of Resident #3's Comprehensive MDS, dated [DATE], revealed the resident had a BIMS of 2, which indicated a severe cognitive deficit. Resident #3 did not exhibit behavioral symptoms. Resident required supervision and set up or 1 person physical assist for ADLs. Record review of Resident #3's Incident Report for event, dated 10/1/21 at 11:30 p.m., revealed the report was completed on 11/12/21 at 12:43 p.m. by LVN A. The report revealed Resident #3 was hit in her mouth by another resident. This incident occurred in the dining area. Resident #3 was not injured. Record review of Resident #3's Incident Report for event, dated 11/4/21 at 1:50 p.m., revealed the report was completed on 11/5/21 at 11:39 a.m. by RN A. The report revealed Resident #3 was struck in the back of her head by another resident with his hand. Resident #3 stated her scalp was tender. Resident #3 did not have any injury noted around her hair follicles. The incident occurred in the living room. Record review of Resident #3's care plan, dated 10/22/21, revealed Resident #3 resided on the secure unit due to elopement risk. Resident #3 was to be monitored to ensure safety and unit should be kept free of possible hazards. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 11/5/21 at 3:00 p.m. with Resident #3, she said she did not know who it was, but someone came up behind her and hit her in the head. Resident #3 was visibly upset, she was crying. She said she was afraid from being hit. She said she didn't know how staff intervened; she was crying. She said it happened before. She rubbed the back of her head and said it hurt. She said she didn't want to come out of her room because she didn't want to get hit again. In an interview on 11/5/21 at 3:00 p.m. with Resident #3's representative party, she said the facility contacted her in October because Resident #3 was hit in the face. She said she was contacted yesterday (11/4/21) because Resident #3 was hit in the back of the head 4 times. She said the facility reported no injuries both times. She rubbed the back of Resident #3's head and said, there were no bumps. She said Resident #3 said she was hurting. She said she spoke with the administrator today (11/5/21) about the 11/4/21 incident. The administrator could not tell her who the resident was who hit Resident #3, but did tell her both incidents involved the same resident. She said it was reported one of the staff left the unit to get linens yesterday when Resident #4 went up behind Resident #3 and hit her 4 times. She said the one staff on duty had to get help. She said she didn't know what staff were present. She said it was reported to her by the administrator, at the time of the first incident, there was only one staff present in the memory care. She said the administrator told her the plan of action was to always have 2 staff present in the memory care unit. She said she was disappointed and concerned when she came onto the unit and only saw one staff for the day. She said she had been concerned about the staffing. Many times there was only 1 staff in the unit. When there were 2 staff, they just sit in a chair by the door. 2. Record review of Resident #4's face sheet revealed a [AGE] year-old male was readmitted to the facility on [DATE] from local psychiatric hospital. Resident #4 had diagnoses which included dementia with behavioral disturbances (memory loss and symptoms of agitation, depression etc), restlessness and agitation (inner tension), peripheral vascular disease (poor circulation to extremities), syncope and collapse (fainting), and hypertension (high blood pressure). Record review of Resident #4's, undated, care plan revealed the resident had behavioral symptoms of wandering throughout the secure unit. Staff approach was to always ask for help if the resident became abusive/resistive, convey acceptance of resident during periods of inappropriate behavior, redirect as needed. Record review of Resident #4's Quarterly MDS, dated [DATE], revealed the resident was discharged to the hospital on 10/2/21. Resident #4 had a BIMS of 0, which indicated severe cognitive deficit. The MDS reveal ed there were zero behavioral symptoms towards others. Resident #4 required supervision with set up only for ADLs. Record review of the facility investigation, for incident dated 10/1/21 at 11:30 a.m., revealed the Administrator completed the investigation. Resident #4 had a history of physical aggression. There was one staff present at the time of the incident. The incident was described as, the staff was sitting in the living room with the residents watching television when Resident #4 got up and left the room. Staff followed Resident #4. Staff was a few feet away when Resident #4 hit Resident #3 in the face. Staff immediately separated the residents and notified the nurse. No injury was noted. Resident #4 hit Resident #3 without provocation. Resident #4 appeared agitated at the time of the investigation. As a result of the investigation, the Administrator sent Resident #4 to psychiatric hospital for evaluation. No additional actions taken. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the Facility Investigation report, for incident dated 11/4/12 at 11:40 a.m., revealed the Administrator completed the investigation. Resident #4 had a history of aggression. There was one staff present at the time of the incident. The incident was described as, Resident #4 hit Resident #3 in the back of the head in the living room area. At the time of the incident, one of the two staff assigned to the unit had gone to get linens and the other staff was providing care to another resident. As a result of the investigation, the Administrator educated Resident #4 of the right other residents have not to be hit. Staff in-serviced on the need to communicate to ensure there was a staff with residents at the living room area at all times. Staff in-serviced on the policy of not leaving the secured unit unattended. Staff were not in-serviced on any interventions for Resident #4. The investigation report did not include any monitoring of Resident #3 for emotional or physical harm. Record review of Psychiatric Services, Initial Evaluation, dated 11/10/21, revealed Resident #4 was referred due to aggressive behaviors, anger, elopement, long-term and short term memory problems. Resident #4 was admitted to the nursing home from a local behavioral hospital. Resident #4 had a diagnosis of bipolar. Record review of Resident #4's Comprehensive MDS, dated [DATE], revealed Resident #4 did not have any behavioral symptoms towards others. The MDS did not reflect the new diagnosis of bipolar. The MDS reflected antipsychotic medication use. Observation on 11/5/21 at 2:00 p.m. revealed one staff present (CNA E) sitting in the entry way of the living room area in the memory care unit. Staff were not with Resident #4. There was not any other staff on the unit. Observation on 11/5/21 at 2:30 p.m. revealed one staff (CNA E) present on the memory care unit. Observation on 11/5/21 at 3:00 p.m. revealed one staff (CAN E) present on the memory care unit. Observation on 11/9/21 at 10:00 a.m. revealed the Activities Director was one of the 2 staff in the memory care unit. CNA H was the other staff on duty in the unit. Observation on 11/30/21 at 5:25 p.m. revealed 2 staff present in the memory care unit, one staff (CNA J) was in the office on the unit. The second staff (CNA K) was exiting a room down the hall. Resident #4 and Resident #3 were observed in the TV room with 8 other residents, unsupervised. Residents were not visible to either CNA. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 11/5/2021 at 2:20 p.m. with CNA E, she said there were 15 residents in the memory care unit. She said she worked the 6 AM to 6 PM shift. She said she was the only aide in the memory care unit today (11/5/21). She said the assigned nurse comes and goes. She said most of the residents had some type of behaviors. She said she worked yesterday, 11/4/21, at the time of the incident between Resident #3 and Resident #4. She was at the linen closet off the unit when the incident occurred. There was an aide present who was in training, but she could not remember her name. The new aide reported Resident #3 was hit by Resident #4. She said Resident #4 had aggressive behaviors and fought during incontinent care. She said it took 2 people to change him. He was care planned for one person assist in toileting. She said she was able to change him by herself earlier because he didn't fight, but that was not always the case. She said there was not another staff to relieve her to take a lunch, she would go into the office on the memory care unit to eat something. She cannot see the residents in the office while she ate. She said she tried to keep Resident #4 away from Resident #3. She said she had not had any additional training for behavior management, nor had she been instructed with interventions for Resident #4's behavior. She said when she provided incontinent care to residents, there was no one watching the other residents when she was by herself. In an interview on 11/5/21 at 2:34 p.m. with Resident #4, he said people were at war repeatedly. He was not able to answer questions directly. When Resident #4 was asked a question, he repeated people were at war. Interview was in the hallway. Resident #4 was not in sight of CNA E. In an interview on 11/5/21 at 8:45 p.m. with CNA F, she said there were 15 residents in the memory care. She said she worked the 6 PM to 6 AM shift. She said all of the residents had some type of behaviors and that was why they were on the secured unit. She said Resident #4 had behaviors of aggression towards staff and residents. She said she had not been in-serviced on any specific interventions for Resident #4. She said she was not aware on any interventions to protect Resident #3 and Resident #4. She said she just tried to keep them separated. In an interview on 11/5/21 at 8:55 p.m. with CNA G, she said she worked the 6 PM to 6 AM shift. She said she was unaware of any interventions in place to protect Resident #3 from Resident #4. She said she tried to keep them separated. She said he was aware Resident #4 had aggressive behaviors, but was not sure how to handle the aggressive behaviors. In an interview on 11/9/21 at 9:55 a.m. with CNA H, she said she was a temporary employee, and this was her fifth day. She said she worked the day shift, 6 AM to 6 PM. She said there were 15 residents in the memory care unit. She said she was not aware of any resident with specialized supervision or interventions. She said she was informed Resident #4 had behaviors of physical aggression when he needed to be changed. She said she spoke Spanish to him and it generally calmed him down. She said she was not given any specific interventions for his aggression. On 11/4/21, she was changing another resident in the resident's room when she heard someone holler. She said she looked out of the resident's room and another resident said Resident #4 was hitting Resident #3. The incident was in the living room. She said no one had to separate the residents because Resident #4 walked away. She said she did not know the name of the other staff she worked with that day, but she left the unit to go get linens. She said the residents were left by unsupervised because the other staff left the unit, and she was in a resident's room providing incontinent care. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 11/9/21 at 10:00 a.m. with the Activities Director, she said she was a CNA and a certified medication technician. She was going through the training to be an activities director. She said the intervention was to remove the aggressor from the area the incident was taking place in and walk the aggressor down the hall to a different area to change the scene. She did not witness either incident between Resident #3 and Resident #4. In an interview on 11/30/21 at 5:25 p.m., CNA J said she was not able to see any residents while she was in the office. She did not know where the other staff were. She said she knew of the behaviors from Resident #4. She said Resident #4 had physical aggressive behaviors towards staff and other residents. She said she was not given any special instruction for Resident #4 and was not aware of special supervision for Resident #4. She said they watched the residents. In an interview on 11/30/21 at 5:30 p.m., CNA K said she knew of the physical aggressive behaviors of Resident #4. She said she could not see any residents while she was in a resident's room. She said she did not know if Resident #4 had any special supervision. She was not given any special instructions. In an interview on 11/30/21 at 1:17 p.m., the MDS Nurse said Resident #4's MDS, dated [DATE], should reflect the behavior on 10/1/21. She said the MDS, dated [DATE], should reflect the new diagnosis of bipolar and the behaviors exhibited on the unit. She said when a psychoactive medication was used for behaviors or diagnosis, the MDS should reflect the diagnosis, medication and behavior. She said the care plan and MDS should correlate. She said she was aware of Resident #4's behavior towards Resident #3. She said Resident #4 was at the psychiatric hospital for about 3 weeks starting 10/2/21. She said she did not change Resident #4's care plan to include any interventions or reflect his aggressive behavior. She said she did not know why she did not, but she should have updated the care plan. She said Resident #4's care plan and MDS needed a change in condition due to the added antipsychotic medication. She said she was the person responsible for implementing interventions. She said she was also responsible for completing the education and updating the staff on the interventions. She conducted in person in-services with the staff when a care plan is updated with new interventions. She said Resident #4's behaviors came on suddenly in October 2021. There were no indications these behaviors were going to start, and likewise, there were no indication the behaviors would stop. Resident #4 was not placed on special supervision. She said she did not update Resident #3's care plan after the incident because she said Resident #3 was not the aggressor. She confirmed that there was not any documentation or assessment completed for the emotional harm Resident #3 sustained or any monitoring of her condition after the incidents. She said to ensure the incidents did not occur again the facility used medications. She said she did not implement specific interventions. She did not complete any in-service with the staff. There were not specific staffing or supervision interventions implemented. (continued on next page)

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Woodland Manor Nursing and Rehabilitation	99 Rigby Owen Rd Conroe, TX 77304

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 11/12/21 at 10:20 a.m. with the Administrator, he said in the secured unit, memory care unit, there were 2 staff. He said the goal was for one of the staff to always keep an eye on Resident #4. He said at the time of the incident on 11/4, one of the staff left the unit to go get linen and only one staff was left on the unit. He said Resident #4 hit Resident #3. He said in October, the incident occurred, he believed there were 2 staff present. He said Resident #4 had a psychiatric evaluation and was not found to be a danger to himself or others. He said he remembered he had a conversation with Resident #3's representative party and she wanted to know what the facility did to prevent further incidents. He said the measures were to have 2 staff present. He said the intervention was one staff always kept an eye on Resident #4. He said on 11/5/21, he was aware there was only one staff present the entire day shift. He said there was a staffing issue for the facility. He said 2 staff were always scheduled for the unit, but sometimes there were call outs. He said he would go in the unit to supervise residents when there was a need. He said the unit was prioritized, but they did not have back up staff to call and fill the shift. He said they used agency staff when possible, but they do not always get what was needed for staffing. He said he wanted to believe the nurses would get on board as well to assist the unit. He said he completed an in-service on the existing policy. He said the policy did not specify 2 staff needed to be in the unit at all times, but he reminded staff during in-service to not leave the unit without a second staff present. He said the intervention was one staff always kept an eye on Resident #4. He said there was not any documentation of any in service with staff for this intervention. If Resident #4 hit another resident, staff were encouraged to talk to him and redirect the resident to follow the staff away from the resident he had targeted. He said Resident #4 started a psychiatric medication when he was re admitted on ,d+[DATE]. Resident #4 had another episode of aggressive behaviors shortly after on 11/4. There was not any specific intervention in place during the time of monitoring the effectiveness of the medication. Record review of the facility Staffing Requirements of the secured unit, dated 5/13/14, revealed the staffing requirements were determined by the DON. Regardless of the census, if the community required additional staff due to increase incidents/accidents the unit would be staffed to ensure resident safety. The secured unit should not be left unattended, a staff member was required to be present at all times. The policy did not specify the need for 2 staff to be present at all times. This was determined to be an Immediate Jeopardy (IJ) on 12/1/121 at 2:04 p.m. The Administrator and DON were notified. The Administrator was provided with the IJ template on 12/1/21 at 2:04 p.m. The following Plan of Removal was submitted by the Administrator and accepted on 12/2/2 at 5:52 p.m.: Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on December 1, 2021, for failing to protect memory care residents by not providing adequate supervision or intervention to prevent abuse. The Director of nursing and Assistant Director of Nursing will audit all events for aggressive behaviors over 90 days that may have been harmed by December 2, 2021. Any residents identified with aggressive behavior will be offered additional services such as psychological services. The other resident involved in the aggressive incident will be assessed by the Social Worker for emotional distress and the need for additional services by December 2, 2021. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Action: To ensure awareness of other residents who may be exhibiting behaviors towards other residents all direct care staff, nursing management, IDT team, and administrator will be educated on POC documentation of behaviors, ensure CNA communication (To include walking rounds, and nurse to CNA instruction at the beginning of each shift to ensure expectations are met and to review implementation and follow through of care plans. This will be monitored through our daily clinical meeting and widgets identifiers. For any identified resident behavior(s) the interdisciplinary team will initiate an intervention care plan update, provide follow-up documentation to include the effectiveness of intervention change. Completion Timeline: December 1, 2021 and going forward to include staff not working at time of in-service (FT, PT, agency, PRN) Training will be conducted by Regional Nurse Manager. Completed on 12/02/2021. Responsible: Administrator, Director of Nursing, Social Services, Assistant Director of Nursing, and IDT team. 2. Action: Administration conducted education with all direct care staff regarding: 1) Notification upon identification of resident behaviors; 2) One-to-one resident monitoring procedure in which a staff member will be assigned to a resident. (They are not to leave them and must be close enough to intercede in any instance where a behavior could cause harm to another resident, visitor, or staff member), and 3) Dealing with resident behavior to include behavior management and intervention and documenting resident behaviors in POC. Beginning December 1, 2021, direct care staff (agency, PRN, new hires) who have not received the above stated education will be educated by Nursing Administration prior to providing resident direct care. Director of Nursing will be responsible for conducting training. Completion Timeline: Beginning December 1, 2021 and going forward to include staff not working at time of in-service (FT, PT, agency, PRN). Training will be completed 12/02/2021 Responsible: Administrator, Director of Nurses, ADON, CCM, Nurse Manager, Charge nurses 3. Action: Residents with aggressive behaviors will be placed on 1:1 monitoring until alternative placement is found or the resident is no longer a danger to other residents or staff as determined by the IDT team. Direct care staff will be educated on what 1:1 monitoring means. No staff will be assigned to provide 1:1 Monitoring until in-service regarding 1:1 monitoring has been done. As a reminder to the expectation 1:1 supervision tool will be placed in sign in book. Administrator will be responsible to ensure that adequate staffing numbers on the unit are always in place to provide adequate supervision including but not limited to when 1:1 monitoring is being provided. There will be at least two staff members on the secure unit at all times. In the event an employee needs to exit the unit, the employee must contact the charge nurse and wait for relief prior to leaving the unit for break and any other task. If a resident is placed on one on one, there will be three staff in the locked unit. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Staff have been educated on communicating with each other when at the memory care unit. If one staff is providing care in a resident's room, the other staff will keep an eye on the residents who may be at the sitting room area. Staff are educated on communicating and taking turns with resident care. In other words, staff who is providing care with residents in their rooms can switch with the staff sitting with residents in the sitting room area. Staff have been in-serviced not to leave residents unattended to in the memory care unit. If a staff member were to leave the unit for break, fetch linens, or run any errands, they cannot leave the unit until they have been relieved. If a staff member were to leave the unit, they would have to reach out to the charge nurse to request for relief. Completion Timeline: December 2, 2021 and going forward to include staff not working at time of in-service (FT, PT, agency, PRN). Completion date 12/02/21. Responsible: Administrator, DON, ADON, Charge nurses, Nurse manager 4. Action: Beginning on December 2, 2021, Residents identified of being affected by deficient practice will have a consult by social worker. If follow up is needed, with consent social services/nursing will request a referral to the psychological service provider. Completion Timeline: December 2, 2021 and going forward to include staff not working at time of in-service (FT, PT, agency, PRN). The social worker will be responsible for interviewing the resident after the occurrence of an aggressive behavior event. . Responsible: Administrator, DON, Social Worker 5. Action: Beginning on December 2, 2021, daily during morning clinical meeting, administrative staff will utilize the open events widget located in the resident electronic medical record to review incident reports for intervention care plan update and follow-up documentation to include effectiveness of intervention change. The IDT team will monitor changes to the care plan to ensure effectiveness and follow up. Event will remain open until intervention(s) are effective. Adhoc QAPI will be completed with Medical Director, Administrator and DON on December 1, 2021. The QAPI Committee will be notified of identified non-compliance. QAPI Committee will develop a Performance Improvement Plan to address identified non-compliance to include staff education and/or disciplinary action. Next QAPI meeting will be held on December 3th, monthly thereafter, and PRN. Completion Timeline: Beginning December 2, 2021, and going forward to include staff not working at time of in-service (FT, PT, agency, PRN) Responsible: Administrator, Director of Nursing 6. Action: Unmanageable Residents will be managed according to policy. Woodland Manor will use the following management approach guidelines to support behavior issues in the facility. Psych evaluation: [The facility] will use psych support to provide help to residents identified with behavior issues. [The facility] will use 1:1 intervention as a means of providing support to residents identified with behavior issues. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Music Therapy: [The facility] will adopt the use of calming music or a resident's favorite type of music as a tool to decrease agitation in a resident. Activities: Woodland Manor will use safe activities as a good way for the resident to get back in touch with their earlier life and find meaning throughout the disease process Socialization: [The facility] will promote more interaction with the residents as much as possible to help decrease agitation in residents with behavior issues. All staff and leadership educated on policies and procedures in identifying at risk residents. All staff in serviced on procedures on policy to promote safety of residents, staff, and visitors. Completion Timeline: December 2, 2021, and going forward to include staff not working at time of in-service (FT, PT, agency, PRN) Responsible: RNM, Administrator, DON, and nurse manager 7. Action: Resident #1 Social Worker will begin working with family and resident for Alternate placement will be sought at one of our more appropriate sister facilities when and if behaviors are controlled and resident is no longer a danger to himself or others. Completion Timeline: December 2, 2021 and going forward to include staff not working at time of in-service (FT, PT, agency, PRN.) Responsible: Administrator, DON, Social Worker Plan of Removal monitoring included the following: Record review was completed for Policies and Procedures which included Identifying Triggers, Identifying Behaviors, Communication between Staff, One to One Observation, Disruptive Behavior, and Not leaving Secure Unattended. Record review of Resident #4's chart included updated care plan and care plan meeting, dated 12/2/21, with RP to discuss behaviors of aggression and additional options for placement at sister facility closer to family. Record review of Resident #3's medical file included an assessment and observations of Resident #3's emotional status and well-being at 3 different times on 12/3/21. Resident #3 was not fearful. Observation and interview of the Resident #3 included resident was out of her room in the TV area. She was talkative to other residents. She stated she was good, happy, and fine. Observations of Resident #4 on different shift, 6 AM to 6 PM, and 6 PM to 6 AM, revealed the resident was on one to one supervision. Resident was not left unsupervised. The secured unit had 3 different staff available on the unit. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of 6 AM shift change and 6 PM shift change revealed staff could not enter the secured unit without seeing manager on duty, ADON, or DON to receive in-service training. Signs were posted on the front door, and the secure unit as well as at the screening station to notify all staff to see manager on duty before shift. Interviews with 10 CNA's included agency staff, and facility staff, and each shift, 6 AM to 6 PM and 6 PM to 6 AM, revealed each CNA was aware of Resident #4's aggressive behaviors. Each CNA was in-serviced on documenting any behavior in Resident #4's file. Each CNA was trained on Resident #4 receiving one to one supervision. The designated staff assigned to Resident #4 was not available to complete any other tasks related to the unit or other residents. Each CNA stated they were trained to wait for relief from another staff member before leaving the unit or leaving Resident #4's side. Interview on 12/3/21 at 12:53 pm., the Administrator said the facility reached out to the family of Resident #4 about a transfer to a facility closer to the family. The family agreed to the transfer. The facility reached out to a sister facility for transfer. The facilities will review Resident #4's file and determine which facility is a better fit for Resident #4. In the meantime, the facility would maintain one to one supervision for Resident #4. Interview on 12/4/21 at 6:13 p.m., DON B said the signs were placed at the entrance, screening station, and memory care door to ensure if a new agency staff came on board, they would receive the training of behaviors, staffing and one to one supervision before starting their shift. The Administrator and DON were informed the Immediate Jeopardy (IJ) was removed on 12/6/21 at 11:32 a. m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 Based on interviews, and record reviews the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 7 resident (Resident #4) reviewed for accurate acquiring, receiving, dispensing, and administering of all drugs, in that: The facility failed to ensure Resident #4 received Trileptal, Risperdal, Neurontin, and Trazadone medications according to physician's orders. This failure could place residents at risk of increased agiation, behaviros and decreased quality of life. The findings included: Record review of Resident #4's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #4 had diagnoses which included Dementia with behavioral disturbances, restlessness and agitation, peripheral vascular disease, syncope and collapse (fainting), and hypertension (high blood pressure). Record review of Resident #4's Comprehensive MDS, dated [DATE], revealed Resident #4 had an antipsychotic medication prescribed. Record review of Resident #4's Physician Order, dated 10/27/21, revealed an order for Risperdal (for bipolar/behaviors) tablet 0.5 mg tablet to be administered 2 times a day. Record review of Resident #4's November 2021 MAR revealed Resident #4 did not receive two doses of his Risperdal 0.5 mg tablet on 11/1, 11/3, 11/6, 11/11, 11/12, 11/15, 11/23, and 11/29. Reason for missed doses were not provided. Record review of Resident #4's Physician order, dated 10/27/21, revealed Neurontin (for anticonvulsant and nerve pain) 100 mg tablet to be administered 3 times a day. Record review of Resident #4's November MAR revealed resident did not receive 1 dose of Neurontin on 11/1, 11/3, 11/6, 11/11, 11/12, 11/15, 11/23, and 2 doses on 11/29. Reason for missed doses were not provided. Record review of Resident #4's Physician Order, dated 10/27/21, revealed trazadone (antidepressant) 50 mg tablet to be administered at bedtime. Record review of Resident #4's November 2021 MAR revealed trazadone 50 mg tablet was not administered on 11/3, 11/6, 11/11, 11/12, and 11/15. Reason for missed doses was not documented. Resident #4 missed his dose on 11/21 due to medication not being available. Documented by LVN F. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Physician order, dated 10/27/21, revealed Trileptal (for seizures) 300 mg tablet to be administered 2 times a day. Order was discontinued on 11/10/21. Record review of Resident #4's November MAR revealed Resident #4 did not receive two doses of Trileptal 300 mg tablet on 11/1, 11/3, and 11/6. Reason for missed dose was not documented. Record review of Resident #4's Physician order, dated 11/10/21, revealed Trileptal 300 mg tablet to be administered 3 times a day. Record review of Resident #4's November 2021 MAR revealed Resident #4 did not receive all doses on 11/11, 11/12, 11/15, 11/23 and 11/29. Reason was not documented. Resident missed a dose on 11/18 due to medication not being available. Documented by LVN F. In an interview on 12/2/21 at 3:47 p.m. the NP said she was not aware Resident #4 refused medications or missed any medications. She said the facility should let her, the provider know. She said she did not have access to look at the MAR. Facility staff had to tell her about missed medications. She said if the facility reported Resident #4 refused medications she would consider different ways to administer medications. She said it would be helpful to know why Resident #4 refused medications. She said missed psychotropic medications could affect Resident #4's behaviors. In an interview on 12/3/21 at 11:43 a.m. with LVN F, she said she was the memory care nurse who administered medications. She said all medications and administration of medications were documented on the electronic MAR, there was not any paper documentation for medication administration. She said when a medication was not given a reason was always documented. She said the physician should always be notified if medication doses were missed for any reason. She said she educated residents about the possible outcomes of refusing a medication, but the memory care residents did not understand. She said Resident #4 would refuse medications sometimes. She tried to give medication a second time and sometimes it was successful and sometimes it was not. She said she only checked the cart for the medication. If it was not available, she reordered it. She said medications should be reordered before they run out. She said any missed dose should be reported to the physician. She said documentation of notifying the physician was done as a progress note. She said she did not notify Resident #4's physician for the missed medications due to refusal or being unavailable. She said she was new and still learning and she didn't know she needed to at the time. In an interview on 12/3/21 at 12:20 p.m. with DON B, she said the expectation of medication administration was to follow the orders. She said a physician and charge nurse, or DON should be notified of any missed medication. She said if a medication was unavailable, the DON should be notified immediately so the DON can check on the reason it was unavailable and correct the problem. She said for essential medications that were refused or missed, the physician and DON should be notified same day. She said for non-essential medications the physician and DON should be notified within 3 days. She said if there was a blank space on the MAR without documentation, then the medication was missed and reason was not documented. She said she was not notified of Resident #4 refusing medications or missing any medications. She said psychotropic medications, and scheduled pain medications were considered essential. Risperdal, trazadone, Neurontin and Trileptal were all essential medications. She said missing these medications could result in increased agitation and aggression. She said if a resident refused medications she would expect the nurse to make multiple attempts. She said she did not have a system developed to ensure medications were given, other than the nurse should notify DON and physician. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Medication and Treatment Orders policy, dated July 2016, revealed medications shall be administered upon the written order. Record review of the facility's facilities Wound Care Policy, dated October 2010, revealed the purpose was to provide the care of wound to promote healing. The physician's order should be verified and followed.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41870 Based on observation, interview and record review the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 1 resident of seven residents (Resident #2) reviewed for therapeutic diets. The facility failed to provide renal diet appropriate foods for Resident #2 as prescribed by the residents physician. This failure could place residents at risk of malnutrition and further kidney complications. Findings Included: Record review of Resident #2's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 had a diagnosis which included abnormality of albumin (suggest a problem with liver or kidneys), End stage. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed the resident had a BIMS of 15, which indicated the resident was cognitively intact. The MDS also stated Resident #2 was on a therapeutic diet. Resident #2 had a diagnosis of end stage renal disease and received dialysis. Record review of Resident #2's, undated, care plan revealed Resident #2 was care planned for dialysis related to renal failure. Interventions were to monitor for fluid excess, instruct in diet restrictions, monitor weight, provide for resident a list of acceptable foods/fluids. Resident #2 was care planned for nutritional status with interventions which included follow diet as ordered. Record review of the Facility Grievance Form, dated 9/11/21, completed by Resident #2's family member, revealed there was a concern for the diet Resident #2 received, she was not receiving a renal diet. Grievance was made to the Administrator. Facility follow up comments completed by the Administrator on 9/15/21 revealed renal diet provided. Record review of Resident #2's physician order report, dated 10/12/21, revealed an order date of 10/6/21 for renal diet, low sodium, potassium, and phosphorus. Special instructions for large protein portions at meals. Have lunch ready at 11 AM every Monday through Friday pre dialysis. Record review of Dietary Communication form, dated 10/6/21, revealed Resident #2 was ordered a Renal Diet, low in Na+ (sodium), K+(potassium), and phosphorus and large protein portions at meals. Record review of the facilities menu revealed a Renal Diet Menu which included the meal of fried fish, parslied noodles, light sodium coleslaw, bread, fruit, tartar sauce, and pepper. Record review of the facility's Renal Diet Menu for 11/9/21 revealed the lunch was backed chicken, steamed rice, cooked vegetable, dinner rolls, fruit, margarine and pepper. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/5/21 at 1:42 p.m. revealed Resident #2 received her lunch tray. A meal ticket was not available with the tray. On her tray was 2 fried fish fillets, coleslaw, macaroni and cheese, and 2 fried hush puppies. In an interview on 11/5/21 at 11:57 p.m. with Resident #2, she said she was a renal patient. She said the food was just not the same. She said sometimes she didn't eat because the food was not the right food for her diet. She said all she ate for breakfast was a cup of coffee. She said she didn't know what was on the menu for lunch today. She said she just wanted the facility to get a renal diet program. In an interview on 11/5/21 at 1:42 p.m. with Resident #2, she said that her tray did not have double meat portions, and she could not eat the macaroni and cheese. She requested a salad to replace the macaroni cheese. In an interview on 11/5/21 at 2:51 p.m. with the Dietary Manager, she said lunch for the residents was fried fish, hush puppies and macaroni and cheese and coleslaw. She said she could recall one resident was on a renal diet. She said the same resident should receive extra protein. She could not remember the resident's name. She said renal diet appropriate foods were any fruits and vegetables, wheat bread but not white bread. Renal diets included oatmeal, pasta and macaroni and cheese. She said for dinner tonight was baked potato with chili and cornbread and dessert. During an observation and interview on 11/9/21 at 12:00 p.m. of Resident #2's lunch tray was three slices of rolled lunch meat (turkey or ham), orange slices, apple slices, and packages of salt free crackers, with orange juice to drink. Resident # 2 said she had dialysis this morning, and she was hungry. She said she was disappointed in her lunch tray. She said she could eat the crackers because they were salt free, and she could eat the apples and the meat. She said she could not drink the orange juice or eat the oranges because it was not approved items for renal diet, and she was hungry. She said this was not what she asked for. She said she did not get appropriate foods for the renal diet and she has even given the facility suggestions. She said she needed the facility to develop a renal menu. In an interview on 11/9/21 at 1:13 p.m. with Resident #2's representative party, she said the facility continues to provide Resident #2 foods that she cannot eat. She said she filed a grievance with the administrator about the diet concerns. She said that the administrator said that he would talk to a nutritionist about the diet and the facility would do their best to accommodate her renal diet. In an interview on 11/12/21 at 10:20 a.m., with the Administrator, he said he was aware of Resident #2 being on a renal diet. He said he received the grievance. He said dietary was aware she was on a renal diet and dietary reported she received a renal diet. He said a renal diet should be provided as the resident needs and the quality and quantity should be as the resident needs. He said orders should be care planned and followed. In an interview on 11/12/21 at 10:20 a.m. with DON B, she said renal diets were generally low sodium potassium and phosphorus. She said macaroni and cheese would not be acceptable, oranges would not be acceptable, orange juice would not be acceptable, and potatoes would not be acceptable to offer a resident on a renal diet. She said Resident #2 was at risk of weight loss, increased kidney damage, and hypertension by not receiving foods appropriate for her diet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675229	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing and Rehabilitation	99 Rigby Owen Rd Conroe, TX 77304

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility Therapeutic Diet policy, dated October 2017, revealed therapeutic diets were prescribed by physician to support the resident's treatment and plan of care, and in accordance with his or her goals. A therapeutic diet was ordered as part of treatment for a disease or clinical condition.