STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675814	A. Building B. Wing	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents for 3 of 20 residents (Residents #29, #35 and #36) reviewed for reasonable accommodations. 1. The facility failed to ensure Resident #29's call button was within reach while in bed and/or recliner. 2. The facility failed to ensure Resident #35's and Resident #36's call button was within reach while sitting in the recliner across the room. These failures could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity. Findings include: 1. Record review of Resident #29's electronic face sheet, dated 01/13/23, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included diabetes (a chronic (long-lasting) health condition that affects how your body turns food into energy), high blood pressure, syncope and collapse (another word for fainting or passing out), stroke (occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts) and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Record review of Resident #29's annual MDS assessment, dated 01/06/23, revealed under Section B, Hearing, Speech, and Vision, she was coded as 1 for usually understands and usually understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 11, which indicated moderately impaired cognition. Section G, Function Status, under section B indicated she needed supervision with transfers and toileting. Record review of Resident #29's comprehensive person-centered care plan, date initiated 02/16/21, and revised on 01/13/23 revealed a Focus indicted: Resident #29 required assist with ADLs and was at risk for deterioration in ADLs: (bed mobility, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathing, transfer, walking in room, walking in corridor, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene) related to cognitive impairment. Intervention indicated: Encourage the resident to call for help before getting out of bed or chair, demonstrate the use of call light, always keep call light in reach, and visible. Inform resident of its location and use. Answer promptly. During an observation and interview on 01/10/23 at 9:19 a.m., Resident #29 was sitting on the side of her bed with the call light clamped to the wall cord, not in reach. Resident #29 said she was on hall 400 but they moved her to hall 500 about a week ago. Resident #29 said she must get up and go fine help, when she needed to call for help. Resident #29 said in her old room she had a button to push for help, but she did not in this room but would like a call button. During an observation on 01/10/23 at 5:20 p.m., Resident #29 sat in her recliner with call light remaining on wall, not in reach. During an interview on 01/10/23 at 5:22 p.m., CNA Q observed Resident #29's call light on the wall. CNA Q said Resident #29 was in her right mind and if she said she did not know where her call light was, she did not. CNA Q placed the call light in reach of the resident. CNA Q said call lights should always be in reach so the residents could let the staff know if they needed anything. Failure to keep the call light in place could lead to a fall for Resident #29. 2. Record review of Resident #35's electronic face sheet, dated 01/13/23, revealed a [AGE] year old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Metabolic encephalopathy (is a problem in the brain. It is caused by a chemical imbalance in the blood), diabetes, high blood pressure, Chronic obstructive pulmonary disease (COPD) (is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Record review of Resident #35's quarterly MDS assessment, with an ARD of 10/07/22, revealed under Section B, Hearing, Speech, and Vision, she was coded as 1 for usually understand and usually understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 10, which indicated moderately impaired cognition. Section G, Function Status, under section G0110 indicated she needed supervision with bed mobility, transfers dressing, eating, personal hygiene and toileting. Record review of Resident #35's comprehensive person-centered care plan dated initiated 03/30/18 and revised on 11/08/22. Focus indicted: Resident #35 had the potential for injury related to risk of falls . with diagnosis of high blood pressure and COPD. Intervention: Instruct/encourage Resident #35 to call for help before getting out of bed or chair, demonstrate the use of call light, always keep call light in reach, and visible. Keep resident informed of its location and use. Answer promptly. During an observation on 01/09/23 at 9:23 a.m. revealed Resident #35 was sitting in the recliner with the call light on the bed, underneath clothing. During an observation on 01/10/23 at 9:13 a.m. revealed Resident #35 was sitting up in her wheelchair and the call light on the bed and was not in reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/10/23 at 12:52 p.m., Resident #35's call light was on the bed and was not in reach. Resident #35 said if she needed anything while sitting in her chair or recliner, she would try her best to get up and alert staff. She said it would be good if she had the call light closer to her in case, she needed to push it. During an observation and interview on 01/10/23 at 4:59 p.m., LVN K observed Resident #35 call light was not in reach when asked where her call light was. LVN K said the call light should be within reach so staff could meet the residents needs and prevent falls. LVN K had maintenance to add a longer call light, so it could reach Resident #35. During an observation and interview on 01/11/23 at 5:43 p.m., Resident #35 was sitting in her recliner with the call light attached on recliner. Resident #35 said she was elated to have her call light on her recliner so she could reach it. 3. Record review of Resident #36's electronic face sheet, dated 01/13/23, revealed a [AGE] year old male resident who was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included Metabolic encephalopathy (is a problem in the brain. It is caused by a chemical imbalance in the blood), high blood pressure, pneumonia (an infection that inflames the air sacs in one or both lungs), depression (feeling of sadness) and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Record review of Resident #36's quarterly MDS assessment, dated 09/29/22, revealed under Section B, Hearing, Speech, and Vision, he was coded as 1 for usually understands and usually understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 10, which indicated moderately impaired cognition. Section G, Function Status, under section B indicated he needed supervision with transfers and toileting. Record review of Resident #36's comprehensive person-centered care plan, date initiated 08/03/16, and revised on 03/14/22 revealed. Focus indicted: Resident #36 was a high risk of falls related to gait/balance problem. Intervention: Be sure resident call light was within reach and encourage him to use it for assistance as needed. During an observation on 01/10/23 at 9:33 a.m. revealed Resident #36 was sitting up in a recliner with the call light hanging on wall behind the bed. Resident #36 stated he yelled if he needed help. Resident #36 said he sometimes slept in his recliner, but mostly in bed and he could reach the call button while in bed. During an observation and interview on 01/11/23 at 4:28 p.m., LVN L observed Resident #36's call light was not in reach when asked where his call light was. LVN L connected Resident # 36's call light to his recliner and said call lights should always be in reach to meet the needs of the resident's and to prevent injury. During an interview on 01/17/23 at 2:06 p.m., the RNC said all residents should always have call lights in reach. The RNC said she expected the charge nurses to make rounds often to ensure call lights were in reach. The RNC said if call lights were not in reach residents' needs would not be meet and it placed them at greater risk of falling. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/17/23 at 2:25 p.m., the ADON said she expected call lights to always be in reach of residents. The ADON said failure to keep call lights in reach could cause resident to fall, receive a bump, bruise or even a fracture. During an interview on 01/17/23 at 5:00 p.m., the Interim Administrator said call lights should always be in reach. The Interim Administrator said administrated staff did rounds to ensure call lights were in reach. Record review of the Call Light: Accessibility and Timely Response policy, revised October 2022, indicated, The purpose of this policy is to ensure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or a centralized location to ensure appropriate response. Staff will ensure the call light is within reach of resident and secure as needed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46310 Based on observation, interviews and record review, the facility failed to ensure residents had the right to a clean, comfortable and homelike environment, which included but not limited to receiving treatment and supports for daily living safety, for 1 of 16 residents (Resident #5) reviewed for a homelike environment. The facility failed to ensure Resident #5's in-room mini refrigerator was cleaned. This deficient practice could place residents at risk of contaminated or expired food or drink products. Findings include: Record review of Resident #5's face sheet, dated [DATE], indicated, a 63- year- old female, who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), hypokalemia (a lower than normal potassium level in your bloodstream), overactive bladder (when the muscles of the bladder start to contract on their own even when the volume of urine in your bladder is low), multiple sclerosis (a disorder of the central nervous system marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control), and generalized muscle weakness. Record review Resident #5's annual MDS assessment, dated [DATE], revealed in in section B the resident was usually understood and usually understood others. The BIMS (Brief Interview for Mental Status) was a 14, which indicated Resident #5 was cognitive intact. Section G indicated Resident #5 required supervision with eating and locomotion on and off unit. Resident #5 required total dependence with transfer, dressing, and toilet use. Resident #5 required extensive assistance with bed mobility and personal hygiene. Record review of Resident #5's comprehensive care plan, dated [DATE], indicated Resident #5 required assistance with ADLs and was at risk for deterioration in ADLs: (bed mobility, bathing, transfer, walking in room, walking in corridor, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene). Interventions for this focus was tnstruct the to call for help before getting out of bed or chair, demonstrate the use of call light, keep call light in reach at all times, and visible. Inform the resident of its location and use and answer promptly. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation with Resident #5 on [DATE] at 10:13 AM, she was observed sitting in wheelchair watching television. A walkthrough of the room was conducted and the minifridge was observed with mold (green and black hair like substance) on a clear container of a white milky substance, there were no dates or labels visibly seen. There was a brown and green substance in all four corners on the bottom of the refrigerator portion. There was a cloudy liquidly film over the bottom of the mini fridge. There were four containers of ensure that were not expired and red and orange Jell-O that had mold on them. Resident #5 said no family members visited or helped clean the mini fridge. She said no staff had come to clean the mini fridge for her. She said a nurse or CNA, she could recall, had given her a bottle of ensure from the refrigerator about one week ago. She said she had not asked that it be cleaned and did not know it needed to be cleaned. During an interview on [DATE] at 11:12 AM, with Housekeeping Aid CC, she said she had not been told by her supervisor or the administrator that housekeeping staff is was responsible for cleaning the resident's in-room mini fridge. She said because of this, she would not know a cleaning schedule for cleaning the mini fridge. She said if a resident asked her to do it, she would. She said they only wiped down the outside but never opened them. She said she was not aware of any resident's mini fridges that needed cleaning . She said it was important to keep the mini fridge clean to prevent food from being expired and the residents could get sick. During an interview on [DATE] at 11:47 AM, with the Housekeeping Director, she said her staff were responsible for wiping down the outside of the in-room mini fridges. She said the facility did not have a policy in place regarding who was responsible for the cleaning the inside of the resident's mini fridge. She said she believed it should be a housekeeping task. She said the risk to residents if their mini fridge was not clean was they could receive contaminated food and lead to foodborne illness. During an interview on [DATE] at 11:51 AM, with CNA P, she said nursing staff were not informed they needed to clean the dependent resident's mini fridge. She said she never cleaned one. She said she thought housekeeping would conduct this task and she saw housekeeping staff clean the outside of the mini fridges. During interview on [DATE] at 6:02 PM, with Administrator, she said there was no policy in place related to the cleaning of the residents' mini fridge. She said her expectation was anyone who said it needed to be cleaned to get it done. She said she would work with corporate to get a policy created. She said the risks to residents was if they received any items from an unclean mini fridge they could be exposed to bacteria, contaminated food and this could lead to foodborne illness.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from neglect for 8 of 20 residents (Residents #5, #120, #121, #44, #119, #32, #38 and #220) reviewed for neglect. 1. The facility failed to effectively monitor Residents #'s #32, #38, #119, and #220 weights, to prevent weight loss, and nutritional deficits. Failed to input weekly weight orders. 2. The facility failed to provide daily wound care to prevent the decline in wound conditions for Residents #'s #120 and #121. Resident #'s 120 and 121 both had Stage 4 sacral wounds decline resulting in hospitalization s for wound infections. Resident #121 died on [DATE] during his hospitalization . 3. The facility failed to implement dietary recommendations timely for Resident #121. 4. The facility failed to provide and maintain offloading devices for Residents #'s #120 and #121. 5. The facility failed to educate the nurses providing wound care. 6.Failed to input wound care orders in the computer system to be completed by the treatment nurses, nurses, or weekend nurses. 7. The facility failed to prevent Resident #5 from obtaining 2 new pressure injuries (DTIs) to both feet. 8. The facility failed to monitor and obtain Resident #44's anticoagulant laboratory results since [DATE]. 9. The facility failed to implement admission orders ensuring residents received the necessary care and services for: 22 of 80 residents with orders in the queue for implementation. 10. The facility failed to implement dietician recommendations timely for Resident #220. 11. The facility failed to implement heel protectors for Resident #5 while in bed according to the physician's orders. 12. The facility did not identify or document the onset or follow treatment orders for the left thumb of Resident #49 after a stage 2 pressure injury was identified by an outside agency. 13. The facility failed to draw routine hemoglobin A1C (HBA1C) (a blood test that shows what your average blood sugar (glucose) level was over the past two to three months) for Resident #35. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	14. The facility failed to obtain Resident #34's Vancomycin (is used to treat infections caused by bacteria. It works by killing bacteria or preventing their growth) trough level (is drawn immediately before the next dose of the drug is administered because it is the lowest concentration in the patient's bloodstream) as ordered prior to administration of first dose of Vancomycin. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 1:20 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of a pattern with the severity of actual harm that was not immediate jeopardy, with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents at risk for negative outcomes and including death. Findings included: Record review of the CMS 672, dated [DATE], indicated in Section G, other. F140 1 resident with unplanned significant weight loss/gain. 1.) Record review of Resident #32's face sheet, dated [DATE], indicated Resident #32 was a [AGE] year-old female who was admitted to the facility on [DATE] with the diagnosis diagnoses which included of stroke, pain, seizures, dysphagia (difficulty swallowing) and malnutrition (lack of nutrition). Record review of Resident #32's consolidated physician's orders, dated [DATE], indicated Resident #32 had a diet order of mechanical soft and nectar thickened fluids, dated [DATE], and a magic cup with lunch and dinner, dated [DATE]. Record review of Resident #32's computerized weights indicated her weight was 153.8 pounds on [DATE] and 141.1 pounds on [DATE]. Record review of a comprehensive care plan dated [DATE] and revised on [DATE] indicated Resident #32 required assistance with her ADLs including assistance with eating, with staff to feed Resident #32 if she was unable to complete the task. The care plan indicated Resident #32 was at risk for weight loss with the goal of maintaining her current level of weight through [DATE]. The interventions included monitor for signs of malnutrition, a weight every month, and report a loss or gain of more than 5%. The comprehensive care plan also indicated Resident #32 was receiving a therapeutic diet and was at risk for nutritional deficit. The goal was Resident #32 would consume adequate fluid and would consume 75% or more of the meals served with no associated weight loss through next review dated [DATE]. The interventions included administer snacks, and supplements as ordered, and provide a magic cup with lunch and dinner dated [DATE]. Record review of an Annual MDS dated [DATE] indicated Resident #32 was sometimes understood and sometimes understands, and Resident #32's BIMs score was 00 indicating severe cognitive impairment. The MDS indicated Resident #2 required total assistance of one staff with meals. The MDS in Section K indicated Resident #32 did not have a swallow disorder or signs of a swallowing disorder. Section K also indicated Resident #32's height was 70 inches, and her weight was 147 lbs. with no weight loss or weight gain documented. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a weight record, dated ,d+[DATE] ,d+[DATE], indicated Resident #32's weight 180 days prior was 151.8 pounds, 90 days prior the weight was 152.8 pounds, and on [DATE] Resident #32's weight was 141.1 pounds. During observations on [DATE] - through [DATE] for Resident #32 revealed the following: -On *[DATE] at 12:55 p.m., there was no supplement with the Resident #32's lunch meal. -On *[DATE] at 5:55 p.m., there was no magic cup with her Resident #32's evening tray. - On *[DATE] at 12:25 p.m., there was no magic cup with her Resident #32's lunch tray. -On *[DATE] at 6:00 p.m., there was no supplement with her Resident #32's evening tray. Record review of the dietician reports revealed the following: -On *[DATE], there was: no mention of recommendations for weekly weights for Resident #32. -On *[DATE], there was: no mention of recommendations for weekly weights for Resident #32. -On *[DATE], there was: no mention of recommendations for weekly weights for Resident #32. -On *[DATE], there was: no mention of recommendations for weekly weights for Resident #32. - On *[DATE], there was: no mention of recommendation for weekly weights for Resident #32. On *[DATE] and [DATE], there was: no mention of recommendations for weekly weights for, Resident #32. 2.) Record review of Resident #38's face sheet, dated [DATE], indicated Resident #38 was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis diagnoses which included of stroke, diabetes (too much sugar in the blood), chronic kidney disease (longstanding disease of the kidney), and muscle weakness. Record review of the consolidated physician orders, dated [DATE], indicated Resident #38 did not have a diet ordered. Resident #38 had orders in a que including which included the diet order waiting for processing. Record review of Resident #38's comprehensive care plan, dated [DATE], revealed there was no care plan addressing the risk of weight loss or actual weight loss. Record review of the clinical records for Resident #38 indicated the Initial MDS was not completed. Record review of Resident #38's computerized weights indicated on [DATE] his weight was 225.0 pounds, and his weight was 190.8 pounds on [DATE]. Record review of a dietician's consultant, dated [DATE], indicated Resident #38 had no recommendations even though the weights indicated he had already lost 25 pounds. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a dietician's consultant report dated [DATE] indicated Resident #38 was not evaluated. Record review of a dietician's consultant report dated [DATE] indicated Resident #38 was not evaluated. Record review of a dietician's consultant report dated [DATE] indicated Resident #38 was not evaluated. Record review of a dietary profile dated [DATE] indicated Resident #38 was receiving a regular diet with no dietary supplements. 3.) Record review of Resident #119's face sheet, dated [DATE], indicated Resident #119 was an [AGE] year-old female who was admitted to the facility on [DATE] with the diagnoses of which included joint replacement surgery, muscle weakness, and high blood pressure. Record review of the Admission MDS, dated [DATE], indicated Resident #119 understood others and she was understood. The MDS indicated Resident #119 had problems with recall and her BIMs score was an 11, indicating which indicated she had moderate impairment with cognition. The MDS indicated Resident #119 required extensive assistance of one staff member with eating. The Section GG of the MDS indicated Resident #119 was independent eating with no assistance. The MDS indicated Resident #119's weight was 130 pounds in the section K0200. The MDS indicated Resident #119 had no weight loss or weight gain in the section of K0300. Record review of a hospital medication consolidation record dated [DATE], indicated on [DATE] Resident #119's weight was 160 pounds, and her height was 62 inches. Record review of a Dietary Profile dated [DATE] indicated Resident #119 was receiving a regular diet and did not require any nutritional supplements. Record review of Resident #119's weights indicated only one weight was obtained since admission on [DATE] of 130 pounds. Record review of the Dietician Recommendation indicated on [DATE] Resident #119 had no recommendations. Record review of a Dietician Progress Note dated [DATE] indicated Resident #119 was eating ,d+[DATE] % of meals, her weight was 130 pounds and stable. The note also indicated Resident #119 had no skin issues. The notes comments indicated the diet was regular diet with thin liquids, to maintain weight without significant change over the next three months and to continue current diet. The dietician note does not indicate there was a significant weight loss from the hospital weight of 160 pounds and the facility weight of 130 pounds. Record review of the dietician reports revealed the following: - On *[DATE] and [DATE], there was: no mention of recommendations for weekly weights for Resident #'s #119. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the comprehensive care plan dated [DATE] indicated Resident #119 was receiving a regular diet with the goal of her weight remaining stable through the next review. The interventions included allow choices in food items, and provide snacks or supplements as ordered. During an observation on [DATE] Resident #119 had consumed 50 % of her meal while in her bed. Record review of the consolidated physician's orders dated [DATE] indicated Resident #119's diet was a regular diet with thin liquids started [DATE]. During an interview with the DON on [DATE] at 3:26 p.m., the DON said she inputs the resident's weights in the computer after their weight was obtained. The DON said the person obtaining the weights just logged the weight obtained. The DON said when she reviews reviewed the weights and, she stars starred them for a reweight to verify the changes. The DON said the hospital weights were often not correct therefore it was important to have a weight. The DON indicated all the systems were a process. During an interview on [DATE] at 2:24 p.m., the ADON A indicated there were no weekly standards of care meetings to review each resident with wounds, weight loss, labs, or accidents. ADON A said she had mentioned this to the management team but was not considered. ADON A said the standards of care meetings was a review of the resident to ensure all the care areas were met. During an interview on [DATE] at 1:36 p.m., LVN L indicated residents should be weighed on admission and monthly. LVN L indicated with not knowing the admission weight there could be a weight loss leading to skin problems, and even the loss of mobility. During an interview on [DATE] at 2:39 p.m., the Regional Nurse Consultant indicated she was unaware of weight loss issues. The Regional Nurse Consultant new admissions should have a weight once a week for 4 weeks or until stable. The corporate nurse indicated the admitting nurse was responsible for obtaining the admission weight. The Regional Nurse indicated there was not a reason for the admission or weekly weights not being obtained. The Regional Nurse Consultant said the DON was responsible for the weight management program. During an interview on [DATE] at 4:55 p.m., the Interim Administrator indicated the physician should be notified when the resident's weight falls fell in the parameter areas of 5% in one month, 7.5% in 3 months and 10% in 6 months either a loss or a gain. The Interim Administrator indicated health issues could arise when weights were not monitored. The Interim Administrator indicated the charge nurses, and DON were responsible for the monitoring of weights. Record review of a Nutritional Management policy, dated [DATE], indicated the facility provides care and services to each resident to ensure the residents maintains acceptable parameters of nutritional status in the context of his or her overall condition. 2. Identification/Assessment: a. Nursing staff shall obtain the resident's height and weight upon admission, and subsequently in accordance with facility policy. C. A comprehensive nutritional assessment will be completed by a dietician within 72 hours of admission, annually, and upon significant change in condition. Follow-up assessments will be completed as needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Weight Monitoring policy, dated [DATE], indicated based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Compliance Guidelines: Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss may indicate a nutritional problem. 5. A weight monitoring schedule will be developed upon admission for all residents: A. Weights should be recorded at the time obtained. B. newly admitted residents-monitor weight weekly for 4 weeks, Residents with weight loss -monitor weight weekly. 6. Weight analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: a. 5% change in one month, b. 7.5% change in 3 months, c. 10% change in 6 months. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions. 4) Record review of Resident #121's face sheet, with the printed date of [DATE], indicated Resident #121 was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of which included sepsis (severe complication of an infection) due to pneumonia, muscle weakness, acute kidney failure, high blood pressure, and malnutrition (lack of caloric needs). Record review of Resident #121's The Admission MDS revealed it was not completed. Record review of a Resident #121's Baseline Care Plan, dated [DATE], indicated Resident #121 required extensive assistance with his ADLs, he had a skin concern of a pressure ulcer to the sacrum, with the goals of the wound to show signs of healing with area decreasing in overall size. The interventions included to provide the wound care/preventative skin care, weekly skin checks, turn and reposition, and notify the physician of any changes in the wound or emerging wounds. The physician orders listed in Section M of the Baseline Care plan did not reveal a wound care order with the medication orders. Record review of Resident #121's Admission-Readmission Assessment, dated [DATE], indicated Resident #121 was admitted to the facility on [DATE] from a hospital. The assessment indicated Resident #121 had a pressure injury to his vertebrae (upper-mid back) measuring 0.2 cm x 0.2 cm x undetermined depth, a coccyx pressure ulcer measuring 0.5 cm x 0.4 cm x undetermined, and a pressure ulcer to the left buttock measuring 0.5 cm x 0.5 cm x undetermined depth. Record review of a Skin and Wound -total Body Skin Assessment, dated [DATE] on admission, indicated Resident #121's skin turgor (skin elasticity) had poor elasticity, the skin color was normal, temperature was cool, the moisture was normal, the condition dry, and had 3 new wounds. The wounds were not specified in the assessment. Record review of a Braden Scale for Prediction Pressure Sore Risk, dated [DATE], indicated Resident #121 had no sensory perception impairment, he was occasionally moist, and he was chair fast with the ability to walk severely limited. The assessment indicated Resident #121 was slightly limited making frequent though slight changes in body or extremity positions independently, his nutrition was probably inadequate, and he required moderate to maximum assistance with moving. Resident #121's score was 15, indicating which indicated the resident was at risk for developing pressure sores. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Daily Skilled Note, dated [DATE], indicated Resident #121's indicated his skin was dry, he consumed 75% of meals, consumes consumed a regular diet with thin liquids. The note did not indicate there were no other skin problems. The skin condition section (6f) of the note failed to indicate pressure ulcers were present. Record review of a Dietician Recommendation, dated [DATE], indicated Resident #121 was recommended to have Pro stat 30 milliliters twice a day due to his albumin level (protein in the blood) was 2.8 with the normal range of 3.4 to 5.4. Record review of a Daily Skilled Note, dated [DATE], indicated Resident #121 had fair, dry and fragile skin. The note indicated Resident #121 fed himself and his intake was 75% or more each meal. The skin condition section of the note failed to indicate 6f. pressure ulcers were present. Record review of a Skin assessment dated [DATE], indicted Resident #121's sacral wound measured 4.0 cm x 3.0 cm x 0.1 cm and was a stage 4 pressure ulcer. The skin assessment report indicated the wound was 100% slough (dead tissue) with a light serous drainage. Record review of an Initial Wound Evaluation and Management Summary, dated [DATE], indicated Resident #121 had a Stage 4 full thickness pressure wound to the sacrum measuring 4.0 cm x 3.0 cm x 0.1 cm. The wound was 100% slough (dead tissue) with a light serous drainage. The wound physician recommended leptospermum honey apply once daily for 30 days, cover with a gauze island with border dressing once daily. The Wound Evaluation indicated Resident #121 had a surgical excisional debridement procedure to remove necrotic tissue and establish margins of viable tissue. The additional note of the wound evaluation indicated post-debridement assess of the previously unstageable necrotic wound had been obscured by necrosis prior to this point. The wound now reveals itself to be a Stage 4 pressure injury. The Wound Evaluation's Treatment Plan indicated leptospermum honey would be applied once daily covered with a secondary dressing with a border. The recommendations included off-load the wound, limit sitting to 60 minutes, reposition according to facility protocol turn side to side and front to back in bed every ,d+[DATE] hours if able, a group 2 mattress, multivitamin daily, vitamin C 500 milligrams twice daily by mouth and zinc sulfate 220 mg once daily by mouth for 14 days. Record review of the medication administration record, dated [DATE], failed to indicate the initial administration and ongoing administration of Vitamin C 500 mg twice daily by mouth or the zinc sulfate 220 mg once daily by mouth for 14 days. The medication administration record indicated the recommendations were started on [DATE], 8 days after the recommendation was given by the dietician. Record review of Resident #121's consolidated physician's orders dated [DATE]-[DATE], failed to indicate a low air loss mattress was ordered with appropriate setting to reflect his actual weight. Record review of the Resident #121's [DATE] Treatment Administration Record indicated Resident #121 had no treatment to his sacral wound until after the wound care physician made his first visit on [DATE]. Resident #121's treatment record indicated there were no previous treatments to his sacral ulcer for 15 days. Record review of a Skin Assessment, dated [DATE], indicated Resident #121's sacral wound measured 3.5 cm x 3.0 cm x 0.1 cm and was considered a stage 4 pressure ulcer. The skin assessment indicated the wound had a light serous drainage and was 100% slough (dead tissue). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a [DATE] of a treatment administration record, indicated Resident #121's treatment to his sacral pressure ulcer was missed on [DATE] and [DATE]. During an interview on [DATE] at 3:00 p.m., ADON A said she had sent Resident #121 to the emergency room related to increase pain to his sacral ulcer. Record review of the Resident #121's progress note, dated [DATE] at 3:34 p.m., indicated Resident #121 was sent to the local hospital for increased confusion, and increased pain. Record review of Resident #121's comprehensive care plan did not reflect a potential impairment of the skin until [DATE]. The care plan indicated Resident #121 had the potential for impaired skin integrity related to decreased mobility, and low protein intake. The goal was to show no evidence of skin breakdown through the next review with the interventions of applying a barrier cream as needed, Braden risk assessment per facility protocol, encourage adequate nutrition and hydration, and keep Resident #121 clean, dry, and sheets wrinkle free, all dated [DATE]. The comprehensive care plan, dated [DATE], indicated Resident #121 had a stage 4 pressure ulcer or the potential for pressure ulcer development related to impaired mobility. The goal was Resident #121's pressure ulcer would show signs of healing and remain free from infection. The interventions were to administer the treatment per the physician orders, do not massage over boney prominences, and use mild cleaners for peri-care. The other intervention, dated [DATE], indicated Resident #121 required turning and repositioning every 2 hours, or more often as needed or requested. Record review of the [DATE] medication administration record indicated Resident #121 had an order for that stated cleanse stage 4 to sacrum and apply leptospermum honey cover with a border gauze once daily. The treatment administration record indicated Resident #121 missed a treatment on [DATE], and [DATE]. Record review of a Weekly Wound Tracking Worksheet dated [DATE] -[DATE], indicated Resident #121 had a Stage 4 pressure wound to his sacrum, with light serous drainage, measuring 4.0 cm x 3.0 cm x 0.1 cm, with the treatment was Medi-honey with a bordered dressing. The form indicated Resident #121 was on the corona virus unit during this assessment period. Record review of the progress note, dated [DATE] at 3:34 p.m., indicated Resident #121 was sent to the local hospital for increased confusion, and increased pain. During an observation and interview on [DATE] at 10:59 a.m., Resident #121 was sitting up in his wheelchair. Resident #121 said his wound on his bottom was hurting and he was administered a pain medication. Resident #121 said his wound care had not been completed. Resident #121's bed sheets had blood-tinged drainage on the sheets approximately where his bottom would have been. During an interview on [DATE] at 8:45 a.m., ADON A was asked to see the wound care for Residents #'s #120 and #121. ADON A said all treatments had been done for the day. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Hospitalist Admission Note, dated [DATE], indicated Resident #121's diagnoses included Sepsis secondary to an unstageable sacral decubitus wound and acute on chronic kidney disease lll likely from the sepsis and congestive heart failure. The note indicated the Cat Scan (CT) of the abdomen/pelvis was positive for subcutaneous gas (gas gangrene a potentially deadly form of tissue death). The note indicated Resident #121 was placed on three broad spectrum antibiotics Vancomycin, cefepime, and clindamycin. The note indicated Resident #121 was referred to the general surgeon for wound debridement. The chief complaint was generalized body aches/pain and a worsening decubitus ulcer. The note indicated in the emergency room the sacral ulcer was foul-smelling. The note indicated he was in no acute distress at rest but does did have exquisite pain on any passive movement due to extensive sacra decubitus wound. The laboratory results listed on the admission note indicated Resident #121's white blood cell count was 16.9 (High) with normal range of 4,000 - 11,000/microliters indication of infection, (Albumin level) 1.8 (low) with normal range of 3.4 to 5.4 g/dl, and BUN (Blood urea nitrogen) was 52 (High) normal range 6 to 24 mg/dl indicating which included his kidneys were not functioning well. Record review of a CT (cat scan) of the pelvis, dated [DATE], indicated subcutaneous defect at the sacrum, with scattered subcutaneous gas about the sacrum at midline, as well as subcutaneous gas within the gluteal musculature bilaterally, left greater than right, with surrounding cellulitis. Findings were concerning for gas-forming infection as can could be seen in the setting of necrotizing fasciitis (flesh eating disease). During a record review of the ER record dated [DATE], a picture taken on arrival to the ER displayed a large sacral wound with base of wound covered with 80% in slough and eschar and the base of the spinal column was exposed. During an observation and interview on [DATE] at 11:30 a.m., Resident #121 was noted to be on the ER gurney at the local ER. Resident #121 stated he had been on the gurney for a day and was waiting a hospital bed because he was being admitted to the hospital for a wound infection. Resident #121 stated he had a large wound on his sacrum that was to the bone. Resident #121 stated it was painful and would not allow visualization of the wound. Resident #121 stated the pressure ulcer had gotten worse since he developed it because he was not being turned and he had gone multiple days with no treatment. During an interview on [DATE] at 12:30 p.m., the hospital SW stated the hospital was running test for sepsis and the resident was being admitted for a wound infection. Record review of a Hospital History and Physical dated [DATE] at 6:17 p.m., indicated Resident #121 was admitted to the hospital for severe sepsis (severe life-threatening complication of an infection secondary because of an infection to an unstageable pressure ulcer. The note indicated Resident #121 was started on two antibiotics for the pressure ulcer infection. The history and physical also indicated Resident #121 was in an acute on chronic kidney failure condition related to the sepsis. The history and physical note indicated in the emergency room , Resident #121's sacral pressure ulcer was foul smelling, extensive, and positive for gases (gas produced by dying tissue). Record review of a Death Summary note, dated [DATE], indicated Resident #121 was treated with pain medication and anxiety medication and died peacefully in the night. The note indicated Resident #121 had intractable pain and the family agreed to make him a do not resuscitate and placed him on palliative care with the intent of discharging to a nursing facility with hospice care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5) Record review of a Resident #120's face sheet, dated [DATE], indicated Resident #120 was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnosis diagnoses which included of bacterial peritonitis (infection of the peritoneal cavity), severe sepsis with septic shock (a life-threatening complication of infection), and an unstageable pressure ulcer of the sacral region (low back). Record review of Resident #120's admission assessment dated [DATE], indicated he had a sacral wound with no measurements included. Record review of a Braden Scale for Predicting Pressure Sore Risk, dated [DATE], indicated he was at risk for pressure injuries. Record review of a Resident #120's Baseline Care Plan, dated [DATE], indicated Resident #120 required extensive assistance of one staff for walking, toileting, locomotion, grooming, bathing, and set up help with eating. The care plan for bed mobility was left blank. The care plan indicated Resident #120 had a surgical wound, pressure ulcer, specify locations of treatment ordered (sacrum, upper back, and abdomen). The goal was the wounds would show signs of healing with area decreasing in overall size. The interventions included skin checks weekly, turn, and reposition frequently to decrease pressure, and wound vac. Record review of the Resident #120's admission-readmission assessment, dated [DATE], indicated Resident #120 had alterations in skin integrity. The assessment indicated he had a sacral pressure wound and an abdominal surgical incision. The assessment had no measurements of Resident #120's wounds. Record review of the [DATE] EMR wound care entry for Resident #120's sacral wound indicated the wound care was not performed on [DATE], [DATE], [DATE], [DATE], and [DATE]. Record review of Resident #120's skin assessment dated [DATE], indicated he had a stage 4 sacral pressure ulcer measuring 10cm x 10cm x 4cm. Record review of a Resident #120's Dietician Progress Note and Recommendations, dated [DATE], indicated Resident #120 was recommended to receive Juven (dietary supplement to enhance wound healing) twice daily. Record review of Resident #120's EMR indicated the dietician recommendation of Juven 1 package twice daily was not implemented but another Arginaid (dietary supplement to enhance wound healing) one packet twice a day was ordered and implemented on [DATE]. Record review of an Initial Wound Evaluation and Management Summary, dated [DATE], indicated Resident #120 had a stage 4 pressure wound to the sacrum measuring 10 cm x 10 cm x 4 cm with 30% of the wound bed slough, 40% granulation tissue, and 30% muscle, facia, and/or bone. The wound care physician recommended off-loading of the wound, and to turn side to side every ,d+[DATE] hours, if able. The wound care note indicated the dressing treatment plan was Dakin's solution apply once daily, cover with abdominal pad. The wound care note indicated the wound care physician performed surgical removal of the devitalized tissue including slough, biofilm, and no-viable periosteum and bone were removed at a depth of 4 cm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on [DATE] at 11:09 a.m., Resident #120 was lying flat on his back on his bed, the wound vacuum was sitting in his wheelchair. Resident #120 said he had been at the facility for 5 days. During an observation and interview on [DATE] at 4:45 p.m., ADON A said Resident #120's wound vacuum will would not seal well due to the proximity to Resident #120's colostomy bag. ADON A indicated she would have to notify the physician for orders. Resident #120 was lying flat on his back. Resident #120's body reaches reached from side to side of the mattress. During an observation on [DATE] at 8:20 a.m., Resident #120 way lying in his bed on a standard hospital bed mattress. Residen [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46310 Based on observation , interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures for 3 of 20 residents (Residents #32, #271, and #221) reviewed for abuse. 1. The facility did not thoroughly investigate or report to the state survey agency when Resident #221 reported allegations of abuse of being pulled out of bed by a staff member. 2. The facility failed to report Resident #271's allegation of neglect timely to HHS. 3. The facility failed to report Resident #32's black eye, an injury of unknown origin, timely to HHS. This failure could place the residents at risk for further potential abuse due to unreported and uninvestigated allegations of abuse, and neglect. Findings include: 1. Record review of Resident #221's face sheet, dated [DATE], revealed, a 61- year- old male who was admitted to the facility on [DATE] with diagnoses which included: malignant neoplasm of prostate (another term for a cancerous tumor), secondary malignant neoplasm of bone (cancer that has started in another part of the body and has spread (metastasized) to the bone via the bloodstream or lymph nodes), congestive heart failure (a condition in which the heart has trouble pumping blood through the body), atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria (the two upper chambers of the heart) fire rapidly at the same time), other anxiety disorders (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and other recurrent depressive disorders (a disorder characterized by repeated episodes of depression, the current episode being severe with psychotic symptoms and with no previous episodes of mania). Resident #221 was discharged to the hospital on [DATE] and expired at the hospital. Record review of Resident #221's admissions MDS assessment, dated [DATE], revealed the resident's BIMS score was 13, which indicated cognition intact. The resident required extensive assistance (staff provide weight bearing support) with two persons physical assistance for bed mobility, and total dependence (full staff performance every time during entire 7-day period) with two persons physical assistance for transfers, dressing and toileting. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #221's care plan, revised [DATE], revealed Resident #221 had ADL (activities of daily living) functional/rehabilitation potential with a self-care deficit, and an intervention that stated requires staff assistance times one for assist bars and times two to enable self-bed mobility. Resident #221 had a terminal prognosis of prostate cancer, and the intervention was to assess the resident's coping strategies and respect resident wishes, encourage support system of family and friends, and work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Record review of facility grievance/complaint report, dated [DATE], taken by the Administrator from the Resident #221. Indicated Resident #221 stated staff member drug him off the bed. He stated he had no feeling from his nipple down. Follow up documentation stated the Administrator spoke with staff and determined who the staff member was. The Administrator noted the staff member would be removed from caring for the resident. The resolution stated, staff member moved to remove from care for Resident #221 . During an interview on [DATE] at 1:11 PM, the Administrator said she had taken the report from Resident #221 back in ,d+[DATE] . The Administrator said she filled out a grievance report. The Administrator said Resident #221 told her that a nurse, name unknown, pulled him out of the bed by his feet onto the floor. The Administrator said she spoke with nursing staff and determined who the resident could have been talking about, but when she took the staff member into the room with Resident #221 to ask if this was her, Resident #221 stated no, it is not. The Administrator said she removed that staff member from working with Resident #221 for that shift. She stated she looked for the investigation report she completed but was unable to locate it. She said she would take the tag for not reporting this one. She said she did not report the incident to HHS but after it was reviewed by the survey team, she realized she should have done so. She said it was important to report all allegations of abuse or neglect to HHS to prevent any further potional abuse or neglect. She said the risks to residents for not reporting an allegation like this, was they could continue to be abused or neglected causing potential phsycal and emotional harm. Record review of the Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, dated [DATE], indicated: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the (continued on next page)

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	675814	A. Building B. Wing	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility.3. Immediately is defined as: . a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury . 33249 2. Record review of Resident #32's face sheet, dated [DATE], indicated a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included stroke (occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts), pain, seizures (a sudden, uncontrolled electrical disturbance in the brain), dysphagia (difficulty swallowing), and malnutrition (lack of proper nutrition). Record review of the comprehensive care plan, dated [DATE] and revised on [DATE], indicated Resident #32 required assistance with her ADLs which included bed mobility. The interventions included to have the assistance of one to two staff for bed mobility. Record review of a skin assessment, dated [DATE], indicated Resident #32 had no alterations in skin integrity. Record review of an incident report, dated [DATE] at 6:31 a.m., indicated Resident #32 was found by a CNA BB to have a bruise to her right eye. The incident report indicated Resident #32 was unable to explain the incident. Record review of a skin assessment, dated [DATE] at 6:44 p.m., indicated Resident #32 had a bruised right eye that appeared sometime during the night. The comments mentioned Resident #32 did not have a fall but possibly occurred during sleeping in bed. During an observation on [DATE] at 12:55 p.m., Resident #32 was sitting in the dining room. Resident #32 was noted to have dark black discoloration to her right eye. During an interview on [DATE] at 1:00 p.m., CNA BB revealed she was the nurse aide for Resident #32. CNA BB said she left at 6:00 p.m. last night and there was not any bruising to Resident #32's right eye. CNA BB said Resident #32 was not combative with care. CNA BB said she reported Resident #32's right eye bruising to the DON and the charge nurses when her shift started at 6am. During an interview on [DATE] at 1:05 p.m., LVN H said when she arrived this morning CNA BB reported Resident # 32 right eye bruising. LVN H said the right eye bruising was reported around 6am to the DON, the family member, and the physician. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:30 p.m., the Administrator said she had just become aware of Resident #32's black eye. The Administrator said neither the nurses nor the DON made her aware of Resident #32's black right eye. The Administrator said she was the abuse coordinator and an injury of unknown origin required reporting within two hours. The administrator said because she was unaware of black eyes until now she would report to HHSC. 46928 3. Record review of Resident #271's face sheet, dated [DATE], indicated a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included right fibula fracture (break in bone that stabilizes and supports your ankle and lower leg muscle), right tibia (shin bone) fracture, anxiety, depression (mood disorder that causes persistent feeling of sadness or loss of interest), and dementia (memory loss). Record review of Resident #271's admission MDS, dated [DATE], indicated Resident #271 was understood and understood others. Resident #271 had a BIMS score of 12, which indicated she had mildly impaired cognition. Resident #271 required extensive assistance with two-person assist for bed mobility, transfers, locomotion, dressing, eating, toileting, and personal hygiene. Resident #271 was totally dependent on bathing. Section E, Behavior, did not indicate Resident #271 had any behaviors. Record review of the comprehensive care plan, dated [DATE], indicated Resident #271 had impaired cognition, was at risk for falls and required assistance with ADLs. The care plan did not have any goals or interventions in place. Record review of the grievance/complaint report, dated [DATE], indicated Resident #271 asked to go to the restroom around 7:30 PM- 8:00 PM on [DATE]. Resident #271 told the Administrator, the aides helped her put her pajamas on, assisted her to bed, she then wet herself and several hours later they changed her. The report indicated action taken was the grievance report and education with the aide. Record review of intake #400136 in salesforce indicated a neglect allegation was reported to the state agency on [DATE] at 07:12 AM. During an interview on [DATE] at 05:21 PM, Resident #271 said on [DATE] around 07:30 PM, CNA Z came to answer the call light. Resident #271 said she asked CNA Z to assist her to the bathroom and CNA Z said No, there is no one here to help me get you up. Resident #271 said she had to urinate in her disposable brief. Resident #271 said by CNA Z not assisting her to the bathroom, it made her feel belittled. Resident #271 said she had not reported the incident to anyone in the facility. During an interview on [DATE] at 12:48 PM, the Administrator said she spoke to Resident #271 on [DATE]. The Administrator said she filled out a grievance report. The Administrator said Resident #271 told her CNA Z did assist her in putting her pajamas on and did change her several hours later. The Administrator said she spoke with CNA Z, and CNA Z had reported to her that she did assist Resident #271 to the bathroom with the help of CNA W. The Administrator said Resident #271 did pressed her call light again that night while CNA W was on break and CNA Z did not take her to the restroom at that time because she didn't think to ask the nurse for help. The Administrator said she did not feel the incident required to be reported during her initial phase of investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:40 PM, the Administrator said a grievance was done on Resident #271's complaint. The Administrator said it was in her policy that it was at her discretion to report or not report to HHSC. During an interview on [DATE] at 1:57 PM, the RNC said she expected an allegation of neglect be reported immediately to the abuse coordinator, nurse, and DON. The RNC said the incident should be thoroughly investigated and be reported the state agency within 24 hours. Record review of the Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, dated [DATE], indicated: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. . a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review the facility failed to have target behavioral monitoring in place for behaviors associated with the use of psychotropic medications and to ensure residents who had not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 3 of 20 reviewed for unnecessary psychotropic drugs (Resident #30, Resident #271, and Resident #36). The facility failed to have an appropriate diagnosis or indication of use for Resident #30's Seroquel (antipsychotic). The facility failed to adequately monitor Resident #271 behaviors and side effects regarding her antidepressant and antianxiety medications. The facility failed to have an appropriate diagnosis or indication of use of Lorazepam (a medication used to treat anxiety) for Resident #36. These failure could place residents at risk of receiving unnecessary psychotropic medications with possible medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. Findings included: 1. Record review of a face sheet dated 01/13/23 indicated Resident #271 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of right fibula fracture (break in bone that stabilizes and supports your ankle and lower leg muscle), right tibia (shin bone) fracture, anxiety, depression (mood disorder that causes persistent feeling of sadness or loss of interest), and dementia (memory loss). Record review of the Resident #271's admission MDS dated [DATE], indicated Resident #271 was understood and understood others. The MDS revealed Resident #271 had a BIMS score of 12, indicating she had mildly impaired cognition. The MDS indicated Resident #271 required extensive assistance with two-person assist for bed mobility, transfers, locomotion, dressing, eating, toileting, and personal hygiene. Resident #271 was totally dependent on bathing. The MDS under section D0200, Resident Mood Interview, indicated Resident #271 had experienced feeling tired or having little energy and trouble concentrating over the last 2 weeks. The MDS revealed under section I, Active Diagnoses, had I5700, Anxiety disorder, and I5800, Depression, checked. The MDS under section N0410, medications received within the last 7 days, had six days Resident #271 received antidepressant medications. The MDS indicated Resident #271 did not receive anti-anxiety medications. Record review of the order summary report dated 01/11/23 indicated Resident #271 had the following orders with start date of 12/20/22: *Buspirone 10mg tablet give one tablet every eight as needed for anxiety (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Cymbalta 30mg delayed release capsule give three capsules one time a day for depression, give 3 capsules to equal 90mg. *Doxepin HCL 10mg capsule give five capsules by mouth in the evening for anxiety, give five capsules to equal 50mg *Paxil 40mg tablet give one tablet by mouth one time day for depression * Remeron 15mg disintegrating tablet give one tablet by mouth at bedtime for depression The order summary report did not indicate Resident #271 had any behavior or side effect monitoring for the use of antidepressant or antianxiety medications. Record review of the comprehensive care plan dated 01/10/23 indicated Resident #271 uses antidepressant medications with an intervention to monitor/document/report to medical director as needed ongoing sign and symptoms of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, and constant reassurance. During an interview on 01/13/23 at 05:34 PM, LVN N said antidepressant and antianxiety medications require to have behavior and side effect monitoring. LVN N said by not monitoring for behaviors or side effects the resident was at risk for taking something they don't need or have an adverse side effect and staff would be unaware of it. During an interview on 01/17/23 at 12:51 PM, ADON A said a resident receiving antidepressant or antianxiety medications should have behavior and side effect monitoring as well. ADON A said if they are not monitoring the side effects or the behaviors they will not know when to notify they medical director regarding the need for medication changes. During an interview on 01/17/23 at 1:57 PM, the RNC said she the nurse entering the order for the antidepressant or antianxiety medication is responsible for ensuring the order for side effect and behavior monitor was included as well. The RNC said by not monitoring side effects or behaviors of antidepressant or antianxiety medications, the staff might miss new behaviors or side effects of new medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the policy titled Unnecessary Drugs- Without Adequate Indication for Use dated 07/01/22 indicated .It is in the facility's policy that each resident's drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs .Indication for use is identified, documented clinical rationales for administrating a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with the manufacturer's recommendations and or clinical practice guidelines, clinical standards of practice, medication reference, clinical studies, or evidence-based review articles that are published in medical and or pharmacy journals .Each resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements: a. dose (including duplicate therapy, b. duration of use, c. indications and clinical need for medication, d. adequate monitoring for efficacy and adverse consequences, e. preventing, identifying and responding to adverse consequences, f. any combination for the reasons stated above . 45879 2. Review of Resident #30's electronic face sheet dated 01/13/23 revealed a [AGE] year-old female was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of diabetes, muscle weakness, Parkinson (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), high blood pressure and dementia. Review of Resident #30's quarterly MDS assessment dated [DATE] revealed under Section B, Hearing, Speech, and Vision, he was coded as 0 for understands and 1 as usually understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 12 for moderately impaired cognition. Section G, Function Status, under section B indicated she needed limited assist with bed mobility, supervision with transfers, dressing, eating, hygiene, bathing, and toileting. Section N, Medication, under N0410 revealed Resident#30 received 7 doses of antipsychotic medication over the last 7 days of the look back period Review of Resident #30's comprehensive person-centered care plan dated 10/14/22 did not indicated anything about Seroquel. Review of Resident #30's physicians ordered revealed an order for Seroquel (a medication that works in the brain to treat schizophrenia)25MG, Give 1 by mouth at bedtime for insomnia. Review of Resident #30's pharmacy recommendations on 10/24/22 indicated; CMS does not allow antipsychotic agent to be used as hypnotics. On 11/16/22 indicated: the following order have incorrect or inappropriate diagnosis and or reasons for use of Seroquel. During an interview on 01/13/23 at 3:00 p.m., the DON said she had not received December pharmacy recommendations and she would notify pharmacy. The DON said she did not know why Resident #30's pharmacy recommendations had not been done. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 1/16/23 at 10:15 a.m., LVN R looked at Resident #30's medication administration record and verified order for Seroquel 25MG at bedtime for insomnia. LVN R said Seroquel was not indicated for insomnia. LVN R said Seroquel was usually given for diagnosis of Schizophrenia. LVN R said nurses had been given an in-service about making sure they had the correct diagnosis for Psychoactive medication. LVN R said failure to make sure you had proper diagnosis could lead to residents receiving the wrong medication. During an interview on 01/17/23 at 2:06 p.m., the RNC said she would expect the nurses to enter a diagnosis for each medication and to ensure the diagnosis was appropriate for each medication. The RNC said nursing management and the pharmacy consultant checked the orders and were responsible to ensure residents are receiving the correct medication. The RNC said failure to have correct medication could lead to side effects from the wrong medication. During an interview on 01/17/23 at 2:25 p.m., ADON D said she expected the charge nurse when receiving the order to have the correct diagnosis. ADON D said the ADON'S are responsible to follow up on new orders to ensure proper diagnosis. ADON D said Seroquel was not the correct medication for insomnia. ADON D said failure to have correct diagnosis could lead to residents receiving unnecessary medication. During an interview on 01/17/23 at 5:00 p.m., the interim administrator said he was not a nurse but was aware this type of medication required a consent and expected nurse management to follow up on all orders. 3. Review of Resident #36's electronic face sheet dated 01/13/23 revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of Metabolic encephalopathy (is a problem in the brain. It is caused by a chemical imbalance in the blood), high blood pressure, pneumonia, depression, and dementia. Review of Resident #36's quarterly MDS assessment dated [DATE] revealed under Section B, Hearing, Speech, and Vision, he was coded as 1 for usually understands and usually understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 10 for moderately impaired cognition. Section G, Function Status, under section B indicated he needed supervision with transfers and toileting. Section N, Medication, under N0410 revealed Resident#36 received 7 doses of anxiety medication and 0 hypnotic medication over the last 7 days of the look back period. Review of Resident #36's comprehensive person-centered care plan dated 06/23/20 when it was initiated, and it was revised on 09/11/22. Focus indicted: Resident #36 have episodes of insomnia . Intervention: Give medication as ordered. Record review of Resident#36's physician orders dated 01/13/23 revealed and order for Lorazepam 0.5MG, Give 1 tablet at bedtime for insomnia. Record review of Resident #36's medication administration record indicated; Resident #36 received Lorazepam 0.5 MG nightly from 01/01/22 through 01/13/22. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/16/23 at 10:00 a.m., LVN O said when receiving orders for psychoactive medication you must know the diagnosis and monitor for side effects. LVN O said failure to have correct diagnosis for medication could lead to resident receiving the unnecessary medication. During an interview on 01/17/23 at 2:06 p.m., the RNC said she would expect the nurses to enter a diagnosis for each medication and to ensure the diagnosis was appropriate for each medication. The RNC said nursing management and the pharmacy consultant checked the orders and were responsible to ensure residents are receiving the correct medication. The RNC said failure to have correct medication could lead to side effects from the wrong medication. During an interview on 01/17/23 at 2:25 p.m., ADON D said she expected the charge nurse when receiving the order to have the correct diagnosis. ADON D said the ADON'S are responsible to follow up on new orders to ensure proper diagnosis. ADON D said lorazepam was not the correct medication for insomnia. ADON D said failure to have correct diagnosis could lead to residents receiving unnecessary medication. During an interview on 01/17/23 at 5:00 p.m., the interim administrator said he was not a nurse but was aware this type of medication required a consent and expected nurse management to follow up on all orders. Record review of facility policy Unnecessary Drugs-Without Adequate Indications for Use dated 07/01/22 indicated, It is the facilities policy that each resident drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being free from unnecessary drugs. Indication for use is identified, documented clinical rationales for administrating a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with the manufacturer's recommendations and or clinical practice guidelines, clinical standards of practice, medication reference, clinical studies,