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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interviews and record review, the facility failed to ensure residents had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 2 of 16 residents (Resident #271 and Resident #5) reviewed for resident rights. *The facility failed to ensure CNA Z treated Resident #271 with dignity when she did not take her to the bathroom on 01/09/23 when asked by the resident. *The facility failed to ensure Resident #5's catheter bag had a privacy cover. These deficient practices could place residents at risk of loss of dignity. Findings include: 1. Record review of Resident #271's face sheet, dated 01/13/23, 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 the 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. Under section H, bladder, and bowel, indicated Resident #271 was frequently incontinent of bowel and bladder. Record review of the comprehensive care plan, dated 01/10/23, indicated Resident #271 required assistance with ADLs. The care plan did not have any goals or interventions completed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/10/23 at 05:21 PM, Resident #271 said on 01/09/23 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 was no one there to help her 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. During an interview on 01/11/23 at 12:48 PM, the Administrator said she had spoken to Resident #271 on 01/10/23. 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 reported to her that she did assist Resident #271 to the bathroom with the help of CNA W. The Administrator said Resident #271 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. Record review of Resident #271's grievance report, dated 01/10/23, indicated Resident #271 said the staff assisted her with pajamas, then assisted her to bed. Resident #271 said when she was in bed she became wet but had to wait several hours for help. Results of action taken indicated the administrator filled out grievance report and did education with the aides. During an interview on 01/11/23 at 6:19 PM, CNA Z said she did not take Resident #271 to the bathroom at that time because Resident #271 required two-person assist for transfers and she asked Resident #271 if she could wait until she had assistance. CNA Z said she didn't think to ask the nurse for assistance in taking Resident #271 to the restroom. 46310 2. Record review of Resident #5's face sheet, dated 01/13/23, 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 10/26/22, revealed 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 cognitively intact. Section G indicated Resident #5 required supervision with eating and locomotion on and off the 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 01/13/23, indicated Resident #5 had a diagnoses which included urinary retention, neuromuscular dysfunction of bladder, and overactive bladder with the presence of a catheter. The interventions for this focus stated: change bag/tubing every two weeks or as needed per physician orders. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation with Resident #5 on 01/09/23 at 10:13 AM, she was observed sitting in her wheelchair watching television in her room. Her catheter bag was visible and urine could be seen, there was; no privacy bag on the wheelchair or visible in the room. Resident #5 said she did not remember if staff covered it after she was assisted with transferring from her bed to wheelchair. She said she could not see it as she had limited use of her neck. She said she would prefer it always remained covered for her privacy . The catheter bag could be seen from the hall when the door was open. Resident #5 had a roommate that saw the catheter bag without a cover. During interview and observation with Resident #5 on 1/10/23 at 9:02 AM, she was observed in bed watching television. Her catheter bag was hung off the side of the bed that faced the room door, there was no privacy bag covering it. Resident #5 said she did not have any catheter care today. She was unsure if the bag had been there and removed, or never placed. During interview and observation with Resident #5 on 1/11/23 at 2:12 PM, she was observed in bed watching television. Her catheter bag was hung off the side of the bed that faced the room door, there was no privacy bag covering it. Resident #5 said she would prefer the bag be covered for her privacy. She said she was embarrased by the bag being uncovered. During an interview on 01/17/23 at 12:51 PM, ADON A, she said she expected all staff to ensure catheter bags were covered with a privacy bag if they noticed it was not covered. She said these things could lead to residents' embarrassment and emotional harm. During an interview on 01/17/23 at 1:11 p.m., CNA S said if she was to provide care to a resident, she would close the door to provide privacy. She said would inform nursing staff if a catheter bag was not covered as CNAs could not perform any catheter care. During an interview on 01/17/23 at 1:13 p.m., LVN C said the door to any resident's room should be closed when care was provided to preserve their dignity. She said she would ensure the resident's catheter bag was in a privacy bag at all times to ensure there was no embarrassment and shame to the resident. During an interview on 01/17/23 at 1:57 PM, the RNC said the residents had the right to ask for assistance to go the bathroom. The RNC said by not assisting them could be a dignity issue or cause infections. She said each resident had a right to privacy in all care. She said a catheter bag should not left for others to see the contents. She said there should be a privacy bag that covered it at all times. She said she expected all nursing staff to ensure this was done for resident's privacy. The RNC said this could cause emotional harm and loss of dignity to the resident. Record review of the facility's policy titled Resident Rights revised on 02/21, indicated Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy on promoting and maintaining resident dignity policy, dated 7/1/22 indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances residence quality of life by recognizing each resident individuality. number one all staff members are involved in providing care to residents to promote and maintain residence dignity and respect residents' rights . #12 states maintain resident privacy.

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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, 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. (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 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. 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. (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 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. 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. (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 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **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 and the facility promoted and facilitated resident self-determination through support of resident choice for 1 of 16 residents (Residents #54) reviewed for residents' rights. The facility failed to ensure Resident #54 was allowed to smoke during designated smoking times at the resident's request. These deficient practices could place residents at risk of feeling controlled and not able to make requests or decisions about their own preferences. Record review of Resident #54's face sheet, dated 1/13/23, revealed the resident, a [AGE] year old female, was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), disorder of the arteries and arterioles (a buildup of fatty deposits in the arteries), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), hallucinations (an experience involving the apparent perception of something not present), and dependence on supplemental oxygen. Record review of Resident #54's Quarterly MDS assessment, dated 12/29/22, revealed the resident's BIMS score was 4, which indicated severe cognitive impairment. The resident required total dependence with locomotion off unit, extensive assistance with transfer, dressing, toilet use, and personal hygiene, and supervision for the tasks of locomotion on unit and eating. Record review of pending orders from the electronic medical record for Resident #54 revealed there were 34 pending orders, dated 12/27/21, which included but not limited to, physician agrees to care plan, admit to skilled part A services, pain assessment before and after as needed medications, offer substitute if resident eats less than 50%, tuberculin purified protein derivative solution, hospice, may receive flu vaccine, may receive pneumonia, and Tuberculosis step screen on admission. Record review of Resident #54's, undated, care plan, revealed Resident #54 had Nicotine addiction and was a smoker, has been assessed to be a supervised smoker, the resident will smoke traditional cigarettes, and the resident had decided she would try nicotine patches to aid in quitting, but have now decided I wan to continue to smoke. Interventions for this focus were the facility would complete smoking assessment as per facility policy and ensure staff aware of my smoking desire, supervision requirements, and type of smoking product(s) used. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interviewed on 1/10/23 at 11:47 AM with Resident #54, she was observed in her bed lying on her stomach. She said she asked a nurse to take her smoking during the 10:00 AM smoking slot but no one ever came. She said that she felt ignored and was upset by this. She was not able to state which nurse she asked. During observation and interview on 1/11/23 at 02:34 PM with Resident #54, she was observed in observed in the area near the nurse's station. She said she was waiting to go for a smoke break and has had been waiting since 10:00 AM. She said she asked nursing staff and no one has taken her. She said she knew the smoking break times but she had preferred smoking time was at 10am daily. She only wanted to smoke once a day at that time. She said that 10am is a smoking break time. Resident #54 was unable to state exactly which nursing staff she asked. During an interview on 01/17/23 at 12:51 PM, LVN O, she said Resident #54 was denied smoke breaks at least five days out of the week. She said her oxygen saturation would get low and staff would have to hurry back inside. She said Resident #54 was oxygen dependent and the oxygen could not go to the smoking area with her. She said Resident #54 had been denied for this reason. She said she does did not know what a smoking assessment, was so she did not know if Resident #54 has documentation in her electronic medical record to reflect a physician statement or orders to deny her right to smoke. She said Resident #54 was ordered nicotine patches, but she refused to wear them and requested to go for a smoke. LVN O said the risk to residents denied of their right was a loss of dignity and felt like they are were in a prison instead of their home. During an interview on 01/17/23 at 1:36 PM, the RNC said she expected resident's right should always be respected. She said a resident had the right to smoke during the smoking schedule if they chose. She said the medical condition was not a factor unless otherwise noted by a physician. She said denial could make a resident feel like a child and not respected. She said it could affect their emotional well-being. During an interview on 01/17/23 at 4:55 PM, the Interim Administrator said he expected the resident's rights to be respected in regard to smoking. He said even if the resident had a chronic lung condition, it was her right to smoke. He said no staff at the facility should have denied that request. He said this was demeaning and could cause the resident to feel a loss of dignity. Record review of the undated facility smoking policy, revealed 18. Smoking assessment will be completed on admission, quarterly, and as needed only on residents who use tobacco and E-cigarette . Record review of electronic medical records for Resident #54 had a smoking assessment completed on, 3/19/21, 6/18/21, 9/18/21, and 12/18/21 no others .smoking assessment dated [DATE], indicated that the resident is cognitive capable of making decision to smoke, the resident does not understand facility smoking policy due to diagnosis of dementia, resident has a history of smoking-related problems that would be hazardous to self or others because oxygen saturation while smoking. It further indicated the resident requires the supervision of a licensed nurse when smoking due to concerns with her oxygen saturation dropping, so the nurse can assist accordingly in such a situation. Record review of the facility policy titled, Resident's Rights, indicated federal and state law guarantee certain basic rights to all residents of the facility. The rights include the resident's right to .self-determination .have the facility respond to his or her grievances

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status for 2 of 20 residents (Residents #5 and #44) reviewed for notification of changes. 1. The facility failed to notify Resident #5's representative when she received 2 new pressure wounds. 2. The facility failed to notify Resident #44's representative and physician when they identified his PT/INR (A prothrombin time [PT] test measures how long it takes for a clot to form in a blood sample. An INR [international normalized ratio] is a type of calculation based on PT test results) level for Coumadin (is a blood-thinning medicine that's used to treat and prevent dangerous blood clots) labs were not drawn as ordered. These failures could place residents at risk of their physician's or responsible parties not being aware of changes in the residents' conditions. Findings include: 1. Record review of Resident #5'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 multiple sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue), sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death), anxiety (what we feel when we are worried, tense or afraid), high blood pressure, and Alzheimer's (a type of dementia that affects memory, thinking and behavior). Record review of Resident #5's quarterly MDS assessment, with an ARD of 10/26/22, revealed under Section B, Hearing, Speech, and Vision, was coded as a 0 indicating she understands and was understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 14 for cognitive intact cognition. Section G, Function Status, under section B indicated she needed extensive assistance with bed mobility, personal hygiene, total assist with transfers, dressing, bathing, and supervision with eating. Section M, Skin Condition, under section M1200 she received pressure ulcer/injury care and application of nonsurgical dressing during the look back period. Record review of Resident #5's comprehensive person-centered care plan, date initiated 12/27/17, and revised on 01/13/23 revealed the Focus indicted: Resident #5 was at risk for further skin breakdown, also had wound to right, distal, lateral calf lower leg and pressure area to right ischium related to immobility, incontinence, and disease process. Intervention indicated: Keep physician and RP informed of the resident's progress. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's physician orders revealed, new treatment orders, placed on 01/05/23, to apply Skin Prep once daily to unstageable DTI (deep tissue injury) on outer aspect of right foot. Record review of Residents #5's nurse notes dated on 1/12/23 at 9:30 a.m., did not indicate any notification to family on 01/05/23 when new wounds were identified, and orders given. During a phone attempt on 01/12/23 at 9:27 a.m., to notify Resident #5's responsible party was attempted and was unsuccessful. During an interview on 01/11/23 at 11:10 a.m., ADON G said the new unstageable DTI areas to left and right feet were identified with the wound care physician on 01/5/23 and she put them on the skin assessment but did not notify the family. ADON G said she should have notified the family of new pressure ulcers to keep them informed of resident's care. During a phone interview on 01/12/23 at 9:50 a.m., revealed Resident #5's RP said he had not been notified of any new skin changes this month. He said he was not aware of any new skin issues. 2. Record review of Resident #44'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 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), seizures (a sudden, uncontrolled electrical disturbance in the brain), aphasia (loss of ability to understand or express speech, caused by brain damage), and high blood pressure (elevated blood pressure). Record review of Resident #44's quarterly MDS assessment, with an ARD of 12/15/22, revealed under Section B, Hearing, Speech, and Vision, he was coded as a 2 indicating he sometimes understands and sometimes was understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 00 for severely impaired cognition. Section G, Function Status, under section B indicated he needed extensive help with bed mobility, transfers, eating and total help with dressing, toileting, personal hygiene, and bathing. Section N, Medications, under section N0410 indicated he received anticoagulant (Coumadin) for 7 days during the look back period. Record review of Resident #44's comprehensive person-centered care plan, date initiated 01/13/21, and revised on 01/14/21 revealed the Focus indicted: Resident #44 had the potential for alteration in bleeding tendencies and increased bruising related to anticoagulants therapy of Coumadin. Interventions indicated: Administer medication as ordered, monitor for side effects and report ill findings to physicians. Record review of Resident #44's physicians orders, dated 01/13/23, revealed Coumadin 7.5MG (milligram), give 1 orally in the evening related to stroke started 07/07/22. Record review of Resident #44 labs revealed the last Coumadin level drawn was 07/13/22 but was ordered monthly. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #44's nurses notes on 01/13/23 did not indicate any notification to the physician or resident representative that Coumadin level had not be drawn as ordered monthly when identified on 01/12/23. During an interview on 01/12/23 at 5:38 p.m., LVN C said she was not aware Resident # 44 was not getting his Coumadin levels drawn monthly as ordered. LVN C said Resident #44 was on Coumadin and should be getting monthly Coumadin levels and failure to get labs could result in bleeding. During a phone interview on 01/13/23 at 8:40 a.m., the Primary Doctor said he was not aware PT/INR levels had not been drawn since 07/13/22. The Primary Doctor said the facility should have drawn the PT/INR level as ordered and notified him of results. The Primary Doctor said failure to draw PT/INR levels could lead to Resident #44 bleeding and having another stroke. During an interview on 01/17/23 at 2:40p.m., the RNC said the representative and physicians should be notified of all changes to resident's care. The RNC said the charge nurses are responsible to notify the representative and physician of any changes. The RNC said administrative nurses were to follow up on all labs and skin changes. The RNC said without labs been drawn as ordered, doctors would not know if the residents were within a therapeutic range; and without notification to the family, they would not know the resident had a change in care. During an interview on 01/17/23 at 5:00 p.m., the Interim Administrator said he expected staff to notify representatives and physicians of any changes to the residents. The Interim Administrator said nursing staff were to follow up on notifications. The Interim Administrator said failure to notify could impede the resident's care. Record review of the facility policy Notification of Changes, dated October 2022, indicated, The purpose of this policy is to ensure the facility promptly informed the resident, consults the resident physician; and notified, consistently with his or her authority, the resident's representative when there is a change requiring notification.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to ensure personal privacy was provided for 1 of 24 residents reviewed for dignity. (Resident #51) *The facility failed to ensure ADON A treated Resident #51 with dignity when she left the door open while providing wound care. These deficient practices could place residents at risk of loss of dignity. Findings included: Record review of Resident #51's face sheet, dated 01/13/23, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included Left hip fracture, Chronic Obstructive Pulmonary Disease (COPD) (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), high blood pressure, atrial fibrillation (abnormal heartbeat) and muscle weakness. Record review of the MDS significant change of status assessment, dated 11/02/22, indicated in section B Resident #51 was usually understood and usually understood others. The BIMS (Brief Interview for Mental Status) was a 15, which indicated Resident #51 was cognitively intact. Section G indicated Resident #51 required supervision with bed mobility, transfers, eating, transfers, and personal hygiene and extensive assist with bathing. During an observation on 01/12/23 at 11:55 a.m., ADON A was providing wound care on Resident #51 with the door open exposing his chest and abdominal area. During an interview on 01/12/23 at 11:59 a.m., ADON A said she was supposed to close the door to provide privacy when providing care to Resident #51, but she did not. ADON A said she knew not closing the door while providing care was a privacy violation and could be a dignity issue for Resident #51. During an interview on 01/12/23 at 12:10 p.m., Resident #51 said his back was located against the door, so he did not realize his door was open when the nurse did wound care on him. Resident #51 said he was not okay with anyone providing care to him with his door open. During an interview on 01/17/23 at 2:06 p.m., the RNC said she expected all staff to provide privacy during care. The RNC said everyone was responsible to make sure the door was closed when care was provided. The RNC said failure to close the door when providing care could lead to embarrassment for the resident. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy on promoting and maintaining resident dignity policy, dated 7/1/22 indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances residence quality of life by recognizing each resident individuality. number one all staff members are involved in providing care to residents to promote and maintain residence dignity and respect residents' rights . #12 states maintain resident privacy.

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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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	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 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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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on interview, and record review the facility failed to ensure residents had physician orders for the resident's immediate care for 4 or 20 residents (Residents #41, #54, #220 and #271) reviewed for admission orders. The facility did not implement the physician orders in the que (pending) for (Residents #41, #54, #220 and #271). This failure could place residents at risk for not receiving appropriate care and treatment services. Findings include: 1. Record review of Resident #41's computerized clinical records, under the section of orders, revealed Resident #41 had 12 orders showing incomplete status since 10/14/2022. The orders included: -*Admit to Long term care -*I have reviewed and concur with the current IDT care plan -*Family/RP aware of resident's medical conditions and current plan of care -*Resident has been informed of DX and medical condition unless contraindicated -*May alter medication by crushing, opening capsules, or administering and/or cocktail all together in food/liquid at one time per MD order due to inability to take all crushed medications individually at every shift unable to tolerate process; becomes tired/full of taking multiple crushed meds individually. -*This resident is free from communicable diseases -*Pressure relieving cushion to wheelchair/recliner/Geri chair -*I hereby certify that this resident requires NH care for 180 days -*Vital signs Q month -*Tuberculin solution 5 unit/0.1milliliter -*Read TB results -*Behavior/Mood Monitoring 0=none, 1= physical, 2=Verbal, 3=Pacing, 4=Disrobing, 5=Hoarding of items, 6=Suspicious or distrustful of others/Delusions, 7=Hallucinations, 8=Refusal to cooperate in routine care, 9=Inattention (difficulty focusing, easily distracted) 10= Taking belongings or food items from others, 11= sadness/crying. Document intervention in PN for any code other than 0. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's face sheet, dated 01/13/2023, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included sepsis (severe blood infection), malnutrition (lack of sufficient nutrients in the body) , intellectual disabilities (below average intelligence), and high blood pressure (a condition in which the force of the blood against the artery wall is too high). Resident #41 did not have a baseline care plan completed. 46928 2. Record review of a Resident #271's face sheet, dated 01/13/23, 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. Record review of the electronic physician orders indicated Resident #271 had 39 queued orders. The following orders showed queued status being incomplete with a queued date of 12/20/22: -*ST (Speech Therapy) to evaluate and treat *PT (Physical Therapy)/ST (Speech Therapy) and OT (Occupational Therapy) to evaluate and treat as indicated *May receive the flu vaccine 0.5 milliliters intramuscular every year as available *May receive pneumonia vaccine 0.5 milliliters intramuscular every 5 years *May use generic drug product unless otherwise specified by physician -*Admit to Skilled Part A services for diagnosis of: -*Admit to long-term care -*I have reviewed and concur with the current IDT (Interdisciplinary Team) care plan -*Family/RP (responsible party) aware of resident's medical conditions and current plan of care -*Resident has been informed of diagnosis and medical condition unless contradicted (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-*May alter medication by crushing, opening capsules, or administering and/or cocktail all together in food/liquid at one time per medical director order due to inability to take all crushed medications individually at every shift unable to tolerate process; becomes tired/full from taking multiple crushed medications individually -* The resident is free from communicable diseases -*Observation of pain-observe every shift. If pain present, complete pain progress note and treat trying non-pharmacologic interventions prior to medicating if appropriate. Document in the progress notes. Patient stated tolerable pain level: (specify) -*Pressure relieving cushion to wheelchair/recliner/gerichair -*I hereby certify that this resident requires nursing home care for 180 days -*Vital Signs every month -*Tuberculin solution 5 unit/0.1milliliter -*Read Tuberculosis results -*Codes for nonpharmaceutical interventions: 0=none, 1=rest, 2=massage, 3=positioning, 4=heat/warm, 5= Range of motion/mobility, 6= Topical cream/ointments, 7= relaxation techniques, 8= therapy, 9= diversion activities, 10=social interaction, 11= redirection, 12= medication type code for interventions used prior to giving as needed (pain/antianxiety, sedative/hypnotic, antipsychotic) medication. -*Behavior/mood monitoring:0= none, 1= physical, 2= verbal, 3 = pacing/wandering, 4= disrobing, 5= hoarding items, 6= suspicious for distrustful of others/delusion, 7= Hallucinations, 8=refusal to cooperate in routine care, 9= inattentions (difficulty focusing, easily distracted) 10= taking belongings or food items from others 11= sadness/crying. Document intervention in the progress note for any code other than '0' -*May go out on pass with meds -*May use generic equivalent medication -*I certify these orders are valid for 60 days unless otherwise stated -*I hereby certify that this resident requires/continues to require nursing facility care for 180 days. -*May crush meds or open capsules as needed unless contraindicated -*Pneumonia vaccination unless contraindicated -*May receive influenza vaccination annually -*Offer substitute if resident east less than 50 percent (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-*Tuberculosis 2 step screen on admission unless contraindicated -*May have pressure reducing mattress -*May attend activities of choice as tolerated -*Family/Responsible party is aware of medical condition -*Pain assessment every shift using PAINAD /Dementia scare 0-10 -*Admit to (facility) under the care of (Doctor) -*Physician agrees with plan of care *Pain assessment before and after as needed medications: utilize 0-10 PAINAD. Document pain scare results, vital signs, interventions, outcomes, in progress notes. Utilize the non-pharmacological pain treatment code: P-position, R- Relaxation, H-Heat, C-Cold, M Music, O-other -*OT (Occupational Therapy) may evaluate and treat as indicated -*ST (Speech Therapy) may evaluate and treat as indicated -*Baseline temperature every shift x 3 than average *put average temperature under vital as the baseline temperature . Resident #271 did not have a baseline care completed. 46310 3. Record review of Resident #54's face sheet, dated 1/13/23, revealed the resident was a [AGE] year old female who was admitted to the facility on [DATE] (readmission 11/26/21) with diagnoses which included: chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), disorder of the arteries and arterioles (a buildup of fatty deposits in the arteries), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), hallucinations (an experience involving the apparent perception of something not present), and dependence on supplemental oxygen. Record review of Resident #54's annual Quarterly MDS assessment, dated 12/29/22, revealed the resident's BIMS score was 4, which indicated severe cognitive impairment. The resident required total dependence with locomotion off unit, extensive assistance with transfer, dressing, toilet use, and personal hygiene, and supervision for the tasks of locomotion on unit and eating. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of pending orders from electronic medical record for Resident #54 revealed there were 34 pending orders, dated 12/27/21, which included but not limited to, physician agrees to care plan, admit to skilled part A services, pain assessment before and after as needed medications, offer substitute if resident eats less than 50%, tuberculin purified protein derivative solution, hospice, may receive flu vaccine, may receive pneumonia, and TB step screen on admission. Record review of Resident #54's, undated, care plan, revealed Resident #54 had risk for alteration in comfort and pain. The interventions for this focus were administer pain medication as ordered by physician and assess effectiveness, comprehensive pain assessment upon admission, re-admission, and change of condition, and review pain medication use to determine if changes in treatment. Resident #54 had been placed on palliative plan for care with diagnosis of chronic pulmonary disease and Heart to Heart Hospice will provide services. The interventions for this focus are administer medications as prescribed by physician for pain, administer oxygen as prescribed by physician for anxiety, ensure resident is comfortable at all times, and notify hospice nurse if any decline in resident's condition. During observation and interview on 1/9/23 at 09:44 AM with Resident #54, she said she required assistance from staff with most her tasks. She said she could not remember the last time she was seen by a physician at the facility. She said she received the care she was supposed to receive from what she was told. She was not able to discuss if she felt she missed any vital care areas or medical needs. Resident #54 said she has been at the facility to more than two years, she did not know which vaccinations she has received or not. Record review of the facility's policy titled Admission Notes dated 09/12, indicated .Preliminary resident information shall be documented upon a resident admission to the facility. 1. When a resident is admitted to the nursing unit, the admitting nurse must document the following information (as each may apply) in the nurse's notes, admission form, or other appropriate place, as designated by facility protocol: h. the time the physician's orders were received and verified Record review of the facility's policy titled Admission Assessment and Follow Up: role of the nurse dated 09/12, indicated . The purpose of this procedure is to gather information about the resident's .for the purpose of managing the resident 11. reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available) and the discharge summary from the previous institution, according to established procedures .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46310 Based on observation, interviews and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care for 2 of 16 resident reviewed (Resident #220 and #271) reviewed for baseline care plans. 1. The facility failed to ensure Resident #220 had a base line care plan completed timely. 2. The facility failed to ensure Resident #271's had a baseline care plan completed timely. These deficient practices could place residents at risk of not receiving care or attention needed. Findings include: 1. Record review of Resident #220's face sheet, dated 1/13/23, revealed the resident was a [AGE] year old male, who admitted to the facility on [DATE] with diagnoses which included: chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), sepsis (the body's extreme response to an infection), Type 2 diabetes mellitus without complications (an impairment in the way the body regulates and uses sugar (glucose) as a fuel), peroration of intestine (a loss of continuity of the bowel wall), paroxysmal atrial fibrillation (terminates spontaneously or with intervention within seven days of onset), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and acute cystitis without hematuria (a sudden inflammation of the urinary bladder). Record review of Resident #220's Quarterly MDS assessment was not completed and was not due according to admitted . Record review of Resident #220's medical record revealed it was missing a baseline care plan. No comprehensive care plan was due according to admitted . During an interview on 01/17/23 at 12:51 PM, ADON A said the facility has two ADONs and they are each responsible for a certain number of residents. She said they are divided by odd and even room numbers and that was how they determined who was responsible for completing the baseline care plan for a particular resident. She said baseline care plans were to be completed within 48 hours of a resident's admission to the facility. ADON A said the risks of not having the baseline care plan completed timely could impact the resident by not receiving the care they require. During an interview on 01/17/23 at 1:57 PM, the RNC said she expected the baseline care plan be completed immediately upon admission. The RNC said administrative nurses were responsible for ensuring the baseline care plans were completed. The RNC said by not completing the baseline care plan timely the nurses and staff will would not know how to care for the resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/17/23 at 04:55 PM, the Interim Administrator said he expected the baseline care plan to be completed within 48 hours. The Interim Administrator said by not completing the baseline care plan timely they would not know how to care for the resident. He said the ultimate responsiblity to ensure a baseline care plan is completed was the DON but that tasks were assigned to the ADONs according to odd and even room numbers. Record review of the facility policy titled Care Plans- Baseline, revised on March 2022, indicated .a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .The baseline care plan includes instructions needed to provide effective, person centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including but not limited to the following: initial goals based on admission orders and discussion with the resident/representative; physician orders; dietary orders; therapy services; social services, and PASARR recommendation, if applicable 46928 2. Record review of Resident #271's face sheet, dated 01/13/23, 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 the 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 bed mobility, transfers, locomotion, dressing, eating, toileting, and personal hygiene. Resident #271 was totally dependent on bathing. Section M, skin conditions, indicated the resident did not have surgical wounds checked. Record review of the order summary report, dated 01/11/23, did not reveal an order for Resident #271's diet, code status or an order to monitor the staples to her right leg. Record review of the admission baseline care plan for Resident #271, dated 01/11/23, revealed the only areas completed were the following sections: A 1. indicated resident required assistance with ADLS related to her fractures., 2a. Resident required extensive assistance with bed mobility and 2b. Resident required extensive assistance with transfers. All other sections on the baseline care plan were not completed. During an observation and interview on 01/09/23, Resident #271 had staples noted to the right upper leg and right inner lower leg. Resident #271 said she admitted to the facility with the staples already in place. During an interview on 01/17/23 at 12:51 PM, ADON A said she was the ADON assigned to Resident #220 and Resident #221 was responsible for completing the baseline care plan within 48 hours of admission. ADON A said the risks of not having the baseline care plan completed timely could impact the resident by not receiving the care they require. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/17/23 at 1:57 PM, the RNC said she expected the baseline care plan be completed immediately upon admission. The RNC said administrative nurses were responsible for ensuring the baseline care plans were completed. The RNC said by not completing the baseline care plan timely the nurses and staff would not know how to care for the resident. During an interview on 01/17/23 at 04:55 PM, the Interim Administrator said he expected the baseline care plan to be completed within 48 hours. The Interim Administrator said by not completing the baseline care plan timely they would not know how to care for the resident . The Interim Administrator said the DON and ADONs were for ensuring the baseline care plans were completed timely. Record review of the facility policy titled Care Plans- Baseline, revised on March 2022, indicated .a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .The baseline care plan includes instructions needed to provide effective, person centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including but not limited to the following: initial goals based on admission orders and discussion with the resident/representative; physician orders; dietary orders; therapy services; social services, and PASARR recommendation, if applicable

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes that met a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 4 of 16 resident reviewed (Residents #57, #119, #49, and #271) for care plans. 1. The facility failed to ensure the comprehensive care plan included goals and interventions for the care of Residents #271 and #57. 2. The facility failed to update Resident # 49's care plan for her left thumb stage 2 pressure injury. 3. The facility did not care plan Resident #119's surgical incision with 29 staples to her right hip. These deficient practices could place residents at risk of not having their individualized needs met, a decline in their quality of care and life, risk for pressure wounds and unwanted pain. Findings include: 1. Record review of Resident #271's face sheet, dated 01/13/23, indicated Resident #271 was a [AGE] year-old female who was 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 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 J for, health conditions, indicated Resident #271 had occasional pain and had repair fractures of the pelvis, hip, leg, knee, or ankle checked. Section M, skin conditions, indicated Resident #271 was at risk for developing pressure ulcers or injuries and did not have surgical wounds checked. Section V, Care Area Assessment (CAA) Summary, had the following areas checked and should be care planned on the comprehensive care plan: *Cognitive loss/dementia * Communication * ADL functional/rehabilitation potential *Urinary incontinence (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Psychosocial well being *Falls *Nutritional status *Dehydration/fluid maintenance *Pressure ulcer *Psychotropic drug use *Pain Record review of the comprehensive care plan, dated 01/10/23, revealed Resident #271 did not have goals or interventions for the following focused areas: *Risk for circulatory impairment, chest pain, irregular pulse, impaired skin integrity *Cognitive impairment *Potential for injury *Potential for spontaneous fractures related to diagnoses of osteoporosis (bones become weak and brittle) *Risk for increased abdominal distress, weight loss, and gastrointestinal bleed related to GERD (chronic acid reflux) * Diagnosis of Hyperlipidemia (excess fats in blood)/Hypercholesterolemia (elevated cholesterol) *Risk for adverse consequences related to receiving psychotropic medications and multiple med use due to 9 plus or more medications *Potential for impaired skin integrity *Assistance with ADLS 2. Record review of Resident #57's face sheet, dated 01/13/23, indicated a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included stroke, chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructive airflow from the lungs), schizophrenia (serious mental disorder that affects how a person thinks, feels, and behaves), and high blood pressure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the admission MDS, dated [DATE], indicated Resident #57 was sometimes understood and sometimes understood others. Section C, cognitive patterns, the BIMS could not be conducted due to Resident #58 was rarely or never understood. Resident #57 required extensive assistance with eating and was totally dependent on bed mobility, dressing, toileting, personal hygiene, and bathing. Section V, Care Area Assessment (CAA) summary, had the following areas checked and should be care planned on the comprehensive care plan: *Delirium *Cognitive Los/Dementia *Communication *Urinary Incontinence *Psychosocial Well-Being *Mood State *Activities *Falls *Nutritional status *Pressure Ulcer *Psychotropic Drug Use *Pain Record review of the comprehensive care plan, dated 12/02/22, revealed Resident #57 did not have goals or interventions for the following focused areas: *Potential for alternation in bleeding tendencies and increased bruising related to use of anticoagulant/antiplatelet therapy *Potential for self-care deficit and decline in ADLs related to stroke *Potential for dehydration *Potential for injury related to falls *Potential for impaired skin integrity related to decrease mobility, incontinence, low albumin level, and low protein intake *Require assistance with ADLS (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Receiving therapeutic or altered consistency diet During an interview on 01/17/23 at 12:51 PM, ADON A said the MDS Coordinator was responsible for completing the comprehensive assessment. ADON A said she expected each focus on the care plan to have goals and interventions in place. ADON A said by not having the goal or interventions in place could place the residents at risk for not having their needs met. During an interview on 01/17/23 at 1:36 PM, the RNC said she expected the care plan to be current to the resident status. The RNC said by not having the goals or interventions they would not be able to provide the care needed to the resident. The RNC said the comprehensive care plan was the responsibility of the MDS Coordinator. During an interview on 01/17/23 at 4:55 PM, the Interim Administrator said he expected the comprehensive care plan be completed and should represent the resident . The Interim Administrator said it was important for the care plan to be completed so staff would know the resident's care needs. Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised on March 2022, indicated .the comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment (Admission, Annual, or Significant Change in status) and no more than 21 days after admission .the comprehensive, person-centered care plan includes measurable objectives and timeframes; includes the resident's stated goals upon admission and desired outcomes; reflects currently recognized standards of practice for problem areas and conditions . 45879 3. Record review of Resident #49's electronic face sheet, dated 01/13/23, revealed a [AGE] year old female who was admitted to the facility on [DATE] with diagnoses which included Respiratory failure (a serious condition that makes it difficult to breathe on your own), gastrostomy status (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), anxiety (what we feel when we are worried, tense or afraid), high blood pressure(elevated blood pressure), and stroke(occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts). Record review of Resident #49's quarterly MDS assessment, dated 01/04/23, revealed under Section B, Hearing, Speech, and Vision, she was coded as a 3 indicated Resident #49 rarely understands and was rarely understood by others. Section C, Cognitive Patterns, under section C0700 indicated she has short term memory loss, C0800 indicated long term memory problems, and C0100 coded as a 3 indicating Resident #49 had severely impaired decision making. Section G, Function Status under section G0110 indicated she required total assist with bed mobility, personal hygiene, dressing, bathing, and eating. Record review of Resident #49's care plan did not reveal anything related to a left thumb stage 2 pressure injury noted on 01/02/23. Record review of Resident #49's nurses notes did not reveal any charting about a left thumb stage 2 pressure injury identified on 01/02/23 until 01/12/23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #49's physicians orders, dated 01/13/23, revealed an order dated 01/11/23 to clean area to left thumb with wound cleanser apply collagen and dry dressing. Change every day and as needed. During an interview on 01/17/23 at 2:06 p.m., the RNC said care plans should be current of resident status. The RNC said if the care plan was not done, staff would not have a good picture of the resident's care. The RNC said the MDS nurse was responsible to update all care plans. During an interview on 01/17/23 at 4:36 p.m., The MDS nurse said she did not update Resident #49's care plan because she did not receive any new order about the left thumb; she was unaware to update care plan. The MDS nurse said it is important to update care plans as soon as possible to reflex care of the resident. During an interview on 01/17/23 at 5:00 p.m., the interim administrator said the MDS nurse was responsible to update the care plan. The interim administrator said the care plan should be representing the resident's whole picture of care. 33249 4. Record review of a face sheet dated 01/11/2023 indicated Resident #119 was an [AGE] year-old female who admitted on [DATE] with the diagnosis of joint replacement surgery, fracture of the right femur, and presence of an artificial right hip joint. Record review of Resident #119's admission assessment dated [DATE] indicated Resident #119 had a right trochanteric (hip) surgical incision. The surgical wound was not measured nor was there documentation indicating how many staples were present. Record review of a comprehensive care plan dated 01/10/2023 and revised on 01/11/2023 indicated Resident #119 had a hip fracture from a fall at her home. The goal was Resident #119 would return to the prior level of function with the interventions of monitor, document, and report to the physician hip fracture complications. The comprehensive care plan did not mention the right hip surgical incision. During an observation and interview on 1/10/2023 Resident #119 said she was worried about her surgical incision to her hip having the staples remaining so long. Resident #119 said she was not sure when she will see the surgeon. During an interview on 01/17/2023 at 2:39 p.m., the Regional Corporate Nurse indicated she would expect the comprehensive care plan to be current and reflect the resident's current status. The Regional Corporate Nurse indicated the MDS nurse was responsible for ensuring the care plan was accurate and current. The Regional Corporate Nurse said the resident's care was discussed in morning meeting, and the MDS reads the resident's notes to ensure the care plan was accurate. The Regional Nurse Coordinator said the care plan should reflect a picture of the care a resident requires. During an interview on 01/17/2023 at 4:55 p.m., the Interim Administrator said the care plan should represent the care needs of the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/17/2023 at 5:00 p.m., the CEO said the care plan should read as though it was a picture of the resident. The CEO said the intradisciplinary team was responsible for the care plans. The CEO said the care plan reflects the care a resident needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46310 Based on observation, interviews and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 5 of 16 resident reviewed (Residents #219, #38, #119, #60, and #121) reviewed for ADL care. 1. The facility failed to ensure Resident #219 received grooming and hygiene according to schedule and desire. 2. The facility failed to ensure Resident #119 received showers as scheduled. 3. The facility failed to ensure Resident #60 was shaved and received showers as scheduled. 4. The facility failed to ensure Resident #121 was shaved and received showers as scheduled. These deficient practices could place residents at risk of not receiving care or attention needed which could lead to unwanted skin irritation and feelings of embarrassment. Findings include: 1.Record review of Resident #219's face sheet, dated 01/13/23, revealed was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included: encounter for orthopedic aftercare, Type 2 diabetes mellitus without complications (an impairment in the way the body regulates and uses sugar [glucose] as a fuel), muscle weakness, nondisplaced intertrochanteric fracture of the left femur (extracapsular fractures of the proximal femur that occur between the greater and lesser trochanter), fracture of the upper ed of the left humerus (a break in the upper part of your humerus near your shoulder), Glaucoma (a condition in which there is a build-up of fluid in the eye, which presses on the retina and the optic nerve), transient cerebral ischemic attack (a temporary blockage of blood flow to the brain), legal blindness (occurs when a person has central visual acuity (vision that allows a person to see straight ahead of them) of 20/200 or less in his or her better eye with correction), and history of malignant neoplasm of the larynx (area of the throat that contains the vocal cords and is used for breathing, swallowing, and talking). Record review of Resident #219's admission MDS assessment, dated 11/27/22, indicated Resident #219 was understood and understood others. It revealed the resident's BIMS score was 14, which indicated cognition was intact. The resident required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. The resident required total dependence with locomotion on and off unit. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #219's care plan, dated 1/13/23, revealed Resident #219 had ADL (activities of daily living) functional/rehabilitation potential with a self-care deficit, and an intervention that stated required staff assistance times one for assist bars and times two to enable self-bed mobility. Resident #219 required a lift for all transfers and toilet use requires one staff assistance. Resident #219 has the potential for dental problems and mouth pain with interventions to assist with teeth brushes. Resident #219 required assist with ADLs and at risks for deterioration in ADLs with interventions to assist with ADLs as needed, allow extra time to complete ADLs, encourage independence with praise, and instruct to resident to call before getting out of bed or chair. During interview and observation on 01/09/23 at 9:27 AM, with Resident #219, he was observed sitting in his wheelchair watching television. He said he had his bed bath this morning. He observed with dandruff and flaky scalp with oily hair. During interview and observation 01/10/23 at 11:17 AM, with Resident #219, he was observed in bed watching television. He said the white substance on his shirt was from his head. He said his scalp itched and he would like his hair shampooed. He said he asked yesterday during his bed bath, but the CNA did not get to it. He said he is new to the facility and does not know the names of staff yet. He said he did not feel strong enough for a shower so he gets cleaned up in bed. Resident #219 said this meant a bed bath. He was observed with dandruff and a flaky scalp with oily hair. He said it did not make him feel bad, he just did not feel clean with his hair like this. During interview and observation on 01/11/23 at 2:53 PM with Resident #219, he was observed sitting in bed watching television. He said he had not had his bed bath today. He said he really wanted his hair shampooed. He was observed with dandruff and flaky scalp with oily hair. Record review of undated shower list indicated Resident #219 was to have a shower on Tuesday-Thursday-Saturdays on the day shift. There were no shower sheets available for review for Resident #219 since admission. During interview on 01/14/2023 at 11:51 AM, with CNA P, she said some aids on the opposite rotation will bath or shower the residents and not wash their hair or clean their nails. She said shower/bath schedules were odd room numbers on Monday, Wednesday, and Friday, and even room numbers were Tuesday, Thursday, and Saturday. She said there was not one particular shift that did the care. She said the morning shift started the showers/baths for the day and the evening shift completed those who are were not done. She said some residents may refuse in the morning shift, but evening shift should ask them at least one more time. She said the staff must complete shower sheets that indicated areas of the body that were cleaned and note any skin issues. She said the same sheet was also where they documented refusal. During an interview on 01/16/2023 at 10:10 a.m., LVN L said she was responsible for the ADLs of the residents. LVN L said the CNAs used the shower list and provided showers accordingly. LVN L said around 4:00 p.m., she started collecting the shower sheets from the CNAs. LVN L said when a resident refused, she would attempt to ask them to shower and document their refusals. LVN L said residents could feel embarrassed when they were not showered. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/17/2023 at 1:59 p.m., the Regional Corporate Nurse said she expected ADLs to be performed daily. The Regional Corporate Nurse said without having ADLs completed a resident could feel bad about themselves or have increased infections. The Regional Corporate Nurse said she expected administrative nurses to be responsible for ensuring residents received their ADLs. During an interview on 01/17/2023 at 4:55 p.m., the Interim Administrator said the CNAs provided the showers according to shower lists. He said the DON was responsible for the oversight of the ADLs. The Interim Administrator said the lack of ADLs could affect the health and dignity of the residents. he Regional Corporate Nurse said the facility had implemented the Ambassador Rounds but she said those rounds would be re-implemented. She said Ambassador Rounds are rounds completed by different department heads with residents regarding thier care each morning. Record review of an Activities of Daily Living (ADL), Supporting policy, dated March 2018, indicated the residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care). 33249 2) Record review of a Resident #119's face sheet, dated 01/11/2023, 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 (hip 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. Section E0200 of the MDS indicated Resident #119 did not have any behaviors that interferes interfered with the resident care. Section E0800 of the MDS indicated there were days when Resident #119 rejected care. Section F0400 indicated having the resident had the ability to choose between a tub bath, shower, bed bath, or sponge bath was very important to Resident #119. Section G of the MDS indicated Resident #119 required extensive assistance of one staff with personal hygiene, and total assistance of one staff with bathing. Record review of the, undated, shower schedule indicated Resident #119 was to have a shower on Tuesday, Thursdays, and Saturdays on the day shift. Record review of [NAME] ADLs computerized flow sheet for the dates of 12/29/2022 - 01/10/2023 indicated Resident #119 had a shower on 12/30/2022 and on 01/09/2023. The flow sheet indicated a code of not applicable on the days of 01/02/2023, 01/04/2023, and 01/06/2023. Record review of a skin assessment shower sheet, dated 12/22/2022, indicated Resident #119 was provided a bed bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation interview on 01/10/2023 at 8:25 a.m., Resident #119 said she needed a shower. Resident #119 said she had not had one in a very long time but could not recall how long. Resident #119 said she was supposed to go to the doctor for her hip and wanted a shower. Resident #119 did not have an odor but her hair appeared unclean. 3) Record review of a Resident #60's face sheet, dated 01/13/2023, indicated Resident #60 was an [AGE] year-old -male who admitted to the facility on [DATE] with the diagnoses of which included sepsis (life-threatening complication of an infection), malnutrition (lack of caloric intake), post-traumatic-stress disorder (mental health disorder triggered by a terrifying event), and bladder cancer. Record review of Resident #60's Admission MDS revealed it was unable to be completed due to MDS not completed. Record review of Resident #60's baseline care plan, dated 01/06/2023, indicated Resident #60 required total assistance of one staff with grooming, hygiene, and bathing. Record review of the, undated, shower sheets indicated Resident #60 was not on any of the hall lists for a shower. Record review of a computerized ADLs flow sheet dated 12/27/2022 - 01/08/2023, indicated Resident #60 was showered on 01/06/2023. Resident #60 was not showered from 12/27/2022- 01/05/2023 and then 01/07/2023 and 01/08/2023. Record review of a Resident #60's skin assessment-shower/bath sheet, dated 12/29/2022, indicated no shower was given on 12/29/2022 due to Resident #60 moving to the COVID- 19 hall. During an observation and interview on 01/09/2023 at 11:00 a.m., Resident #60 was resting in bed with his spouse family member at his bed side. Resident #60 had facial hair of 1 1/2 inches long. Resident #60 and his spousefamily member said he had never had a beard only a mustache. Resident #60 said he wished to have a shave. Resident #60 said he had not had a shower since he arrived at the facility. Resident #60 appeared to have unclean hair with white flakes. 4) Record review of Resident #121's face sheet with the printed date of 1/13/2023 indicated Resident #121 was a [AGE] year-old male who admitted on [DATE] with the diagnoses of Sepsis (life threatening complication of infection) due to pneumonia, muscle weakness, acute kidney failure, high blood pressure, and malnutrition (lack of caloric intake). Record review of a Resident #121's care plan, dated 01/10/2023 and revised on 01/12/2023, indicated Resident #121 required assistance with his ADLs. The goal was Resident #121 would maintain a sense of dignity by being clean, dry, odor free, well-groomed and will have no measurable decline in ADL functional ability through the next review. The intervention for Resident #121 was assist with his ADLs. Record review of an the, undated, shower list indicated Resident #121 was to have a shower on Tuesday-Thursday-Saturdays on the day shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a computerized bath sheet dated 12/29/2022 - 01/13/2023, indicated Resident #121 had one shower on 01/09/2023. The computerized shower sheet indicated Resident #121 did not have a shower provided on 12/29/2022 through 01/08/2023, and then 01/10/2023 through 01/13/2023. During an observation and interview on 01/09/2023 at 10:59 a.m., Resident #121 had facial hair one inch long over much of his face. Resident #121 said he had never worn a beard and wanted to be shaved. Resident #121 said he felt unclean. During an interview on 01/16/2023 at 10:03 a.m., CNA CC said has worked the day shift on all halls since October 2022. CNA CC said the shower list was how she knew to provide showers to residents. CNA CC said staffing issues caused baths and charting to go not completed. CNA CC said not having a shower could make a resident feel bad about themselves and may not want to interact with others. During an interview on 01/16/2023 at 10:10 a.m., LVN L said she was responsible for the ADLs of the residents. LVN L said the CNAs used the shower list and provided showers accordingly. LVN L said around 4:00 p.m., she starts started collecting the shower sheets from the CNAs. LVN L said when a resident refusesrefused, she will would attempt to ask them to shower and document their refusals. LVN L said residents could feel embarrassed when they were not showered. During an interview on 01/17/2023 at 1:24 p.m., CNA DD said she worked on the front halls 100 and 200. CNA D said she used the shower list to know who requires required showeringshowers. CNA D said she always provided her showers unless there was were no towels or wash clothes. CNA D said running very low or out of towels and wash clothes occurred often. During an interview on 01/17/2023 at 1:28 p.m., LVN L said to her knowledge showers were provided. All though, LVN L said she did not round to ensure showers and shaving was were provided. LVN L indicated she was not ensuring bathing was completed. During an interview on 01/17/2023 at 1:59 p.m., the Regional Corporate Nurse said she expected ADLs to be performed daily. The Regional Corporate Nurse said without having ADLs completed a resident could feel bad about themselves or have increased infections. The Regional Corporate Nurse said she expected administrative nurses to be responsible for ensuring residents received their ADLs. The Regional Corporate Nurse said the facility had implemented the Ambassador Rounds (department head rounds to ensure care and services were delivered) but she said those rounds would be re-implemented. During an interview on 01/17/2023 at 4:55 p.m., the Interim Administrator said the CNAs provided the showers according to the shower lists. He said the DON was responsible for the oversight of the ADLs. The Interim Administrator said the lack of ADLs could affect the health and dignity of the residents. Record review of an Activities of Daily Living (ADL), Supporting policy, dated March 2018, indicated the residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care).

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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** 33249 Based on observation, interview and record review, the facility failed to ensure based on the comprehensive assessment, residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices for 1 of 20 residents (Resident #119) reviewed for quality of care. The facility did not obtain orders to remove 29 staples from Resident #119's hip when she had missed appointments with the surgeon on 01/04/2022, and 01/11/2022 due to no facility transportation. These deficient practices could affect place residents at the facility who required care and could result in risk of missed or inappropriate care. Findings included: Record review of a Resident #119's face sheet, dated 01/11/2023, indicated Resident #119 was an [AGE] year-old female who was admitted to the facility on [DATE] with the diagnosis diagnoses which included of joint replacement surgery, fracture of the right femur (broken leg), and presence of an artificial right hip joint (surgical hip replacement) Record review of Resident #119's admission assessment, dated 12/19/2022, indicated Resident #119 had a right trochanteric (hip) surgical incision. The surgical wound was not measured nor was there documentation indicating which indicated how many staples were present. Record review of an Admission MDS, dated [DATE], indicated Resident #119 understands and was understood. The MDS indicated in Section I 3900 indicated the resident had a hip fracture. Section J of the MDS indicated a hip replacement. Section M1040 failed to indicate Resident #119 had a surgical wound. Record review of hospital discharge orders for Resident #119 indicated she had a ground level fall and required a right hip replacement. The discharge orders indicated to remove the dressing to the right hip in 5 days. The discharge orders, dated 12/19/2022, indicated to follow up with the surgeon on 01/04/2022 at 9:00 a.m. Record review of the weekly wound tracking worksheet dated 01/02/2023 - 01/06/2023, failed to indicate any documentation of Resident #119's surgical incision to the right hip with 29 staples. Record review of a comprehensive care plan, dated 01/10/2023 and revised on 01/11/2023, indicated Resident #119 had a hip fracture from a fall at her home. The goal was Resident #119 would return to the prior level of function with the interventions of monitor, document, and report to the physician hip fracture complications. The comprehensive care plan did not mention the right hip surgical incision. (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 a progress note, dated 01/11/2023, indicated the charge nurse notified the medical director concerning Resident #119 continued to have staples in her right hip area, and Resident #119 had missed 2 appointments with the surgeon. The staples were clean, dry, and intact with no drainage. The note indicated Resident #119 had redness to the top and bottom areas of the staples. Resident #119's appointment has beenwere rescheduled for 01/16/2023 at 1:20 p.m. The note indicated the charge nurse had requested for the staples to be removed. Record review of Resident #119 physician's orders indicated the medical director ordered, on 1/12/2023, the removal of Resident #119's staples to her right hip. Record review indicated this was the only physician's order obtained to remove Resident #119's staples. During an observation and interview on 1/10/2023, Resident #119 said she was worried about her surgical incision to her hip having the staples remaining so long. Resident #119 said she was not sure when she will would see the surgeon. Resident #119 said she was aware of the missed appointments. During an interview on 01/10/2023 at 2:30 p.m., Resident #119's surgeon's office indicated her appointment was scheduled for 01/04/2023 but was cancelled by the facility and the new appointment was 1/11/2022 at 9:00 a.m. The physician's office indicated the facility's transportation van was out of service. During an interview with the Transportation Aide on 01/10/2023 at 2:40 p.m., she said the facility van has had been in the shop, the non-emergency transportation the alternate transportation method was booked up, and she had to reschedule Resident #119's appointments. During an observation and interview on 01/11/2022 at 10:45 a.m., Resident #119's right hip had 29 staples. The surgical incision appeared red in color around the staples. Resident #119's nurses, LVN Y and LVN B, indicated Resident #119's appointment was now rescheduled again for 1/16/2022 at 1:20 p.m. due to the facility van not available due to being in the shop. LVN B and LVN Y said they had not notified the surgeon of the missed appointments and to clarify the need for removal of the staples. The nurses said the surgical incision could become infected and the staples could grow into the skin due to the staples being in the leg since before her admission on 12/19/2022. LVN B and LVN Y said staples usually were removed in 7-14 days. Record review of a progress note dated 01/11/2023 indicated the charge nurse notified the medical director concerning Resident #119 continued to have staples in her right hip area, and Resident #119 had missed 2 appointments with the surgeon. The staples were clean, dry, and intact with no drainage. The note indicated Resident #119 had redness to the top and bottom areas of the staples. Resident #119's appointment has been rescheduled for 01/16/2023 at 1:20 p.m. The note indicated the charge nurse had requested for the staples to be removed. Record review of Resident #119 physician's orders indicated the medical director ordered on 1/12/2023 the removal of Resident #119's staples to her right hip. During an interview on 01/17/2023 at 1:55 p.m., the Regional Nurse Consultant said removal of staples was according to the physician's orders. The Corporate Nurse said the nurses and DON were responsible for notifying the physician for orders regarding the removal of the staples when appointments were missed. The Corporate Nurse said the surgical incision could become infected when the staples were left too long. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/17/2023 at 4:55 p.m., the Interim Administrator indicated he was not a nurse, had never had staples, and was unsure of the risk. He stated but the nurses were responsible. Record review of the American family physician website, located at https://www.aafp.org/pubs/afp/issues/2008/1015/p945.html accessed on 01/23/2023, indicated on Table 2 the staples to legs should be removed in 10 to 14 days. Record review of the facility's a Wound Treatment Management policy, dated 07/01/2022, indicated to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. 5. Treatment decisions will be based on: a. Etiology of the wound: ii. Surgical

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review the facility failed to ensure residents with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 4 of 20 residents (Residents #5, #49, #120, and #121) reviewed for pressure injury. *The facility failed to provide wound care to Resident #121s sacral pressure injury until [DATE], which was 15 days after his admission with pressure injuries. *The facility failed to consistently provide wound care for Resident #121 after beginning wound care, missing treatments on [DATE] and [DATE]. *The facility failed to implement a dietician recommendations of Pro-stat (given to provide body with additional protein to promote healing) for Resident #121 on [DATE] until [DATE] , 8 days after the recommendation was made. *The facility failed to administer the initial and on-going minerals and vitamins to Resident #121 as ordered by the wound care physician on [DATE]. *Resident #121's sacral wound deteriorated and increased in size from 0.5 cm x 0.4 cm x undetermined depth on [DATE] to 4.0 cm x 3.0 cm x 0.1 cm on [DATE]. Resident developed an infection in his wound and was admitted to the hospital [DATE] with a diagnosis of sepsis secondary to an unstageable sacral decubitus wound. Resident # 121 died [DATE]. *The facility failed to measure Resident #120's sacral wound upon admission. *The facility failed to implement the wound care physician's orders to offload Resident #120's pressure ulcer. *The facility failed to provide Resident #120 a low air loss mattress to prevent wound decline. *The facility failed to provide daily wound care to Resident # 120's sacral wound as ordered on [DATE], [DATE], [DATE], and [DATE]. *The facility failed to prevent Resident #120's wound from becoming infected requiring which required hospitalization . *The facility failed to prevent Resident #5 from developing two new DTIs (deep tissue injuries), one on her left inner bottom of her foot, and one on the right outer foot. (DTIs caused from bilateral feet pressure against each other) The facility failed to document newly identified DTIs and implement treatment orders for Resident #5 when the wound care physician identified the new wounds on [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*The facility failed to identify the onset or followup orders for the left thumb of Resident #49 which resulted in a stage 2 pressure injury. An immediate Jeopardy (IJ) situation was identified on [DATE] at 4:35 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of a pattern with actual harm that was not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the effectiveness of the corrective systems. These failures placed residents at risk of pain, worsening of wounds, wound infection, emotional distress, harm or even death. Findings included: 1. Record review of Resident #121's face sheet, with the printed date of [DATE], indicated a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Sepsis (severe complication of an infection) due to pneumonia, muscle weakness, acute kidney failure, high blood pressure, and malnutrition (lack of caloric intake). 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 an 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], 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 Fall Risk Assessment, dated [DATE], indicated Resident #121 did not display resisting of care, he would eliminate with assistance, and required hands on assistance with moving from place to place. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. Record review of a Daily Skilled Note, dated [DATE], indicated Resident #121 indicated his skin was dry, he consumed 75% of meals, consumed a regular diet with thin liquids. The note did not indicate there were no other skin problems. The skin condition section of the note failed to indicate 6f. 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 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 the [DATE] medication administration record indicated the recommendations were started on [DATE], 8 days after the recommendation was given by the Dietician. 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 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. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 a Daily Skilled Note, dated [DATE], indicated Resident #121 had dry skin. In the section of 6f. of the Daily Skilled Note there were no pressure ulcers documented. Record review of a Wound Evaluation and Management Summary, dated [DATE], indicated Resident #121's sacral wound remained a stage 4 full thickness wound. The wound measured 3.5 cm x 3.0 cm x 0.1 cm, with 100% slough. The recommendations continued to be the multivitamin daily, Vitamin C 500 mg twice daily by mouth and zinc sulfate 220 mg once daily by mouth for 14 days. The wound note indicated Resident #121's wound was surgically debrided removing the necrotic tissue and establish margins of viable tissue. The treatment was leptospermum honey cover with a gauze island dressing with a border once daily. 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). 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]. 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. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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. 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. 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 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. (continued on next page)

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 2.) Record review of Resident #120's face sheet, dated [DATE], indicated he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included bacterial peritonitis (infection of the peritoneal cavity), severe sepsis(severe complication of an infection) with septic shock, and an unstageable pressure ulcer of the sacral region. Record review of the admission-readmission assessment, dated [DATE], indicated Resident #120 had alterations in skin integrity. The assessment indicated he had a sacral pressure wound. The assessment had no measurements of Resident #120's wounds. Record review of a Braden Scale for Predicting Pressure Sore Risk, dated [DATE], indicated he was at risk for pressure injuries. 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 which included slough, biofilm, and no-viable periosteum and bone were removed at a depth of 4 cm. 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. 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 would not seal well due to the proximity to Resident #120's colostomy bag. Resident #120 was lying flat on his back. Resident #120's body reached from side to side of the mattress. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on [DATE] at 8:20 a.m., Resident #120 appeared to be taking up the entire mattress. The wound vacuum device was sitting in his wheelchair and not connected to Resident #120 abdomen. Resident #120 was lying on his back, and there was not a specialized mattress underneath Resident #120. Record review of Resident #120's electronic medical record 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 the physician's orders, dated [DATE], indicated Resident #120 had an order received on [DATE] for the stage 4 sacral wound to cleanse wound with wound spray use barrier cream around the wound skin, apply ,d+[DATE] strength Dakin's-soaked gauze to wound base then cover with dry gauze and secure with abdominal pad, secure with foam tape, change daily, and as needed for saturation or dislodgement. 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] according to the physician's orders dated [DATE]. During an interview on [DATE] at 10:00 a.m., the Wound Care Physician indicated he was unaware of Resident #121 not receiving wound care for 7 days after he provided orders on [DATE]. The Wound Care Physician indicated he would expect all residents who had a Stage 3 or Stage 4 pressure ulcer to have a low air loss mattress, and he was unaware Resident #120 had not had a low air loss mattress. The physician said he would expect the facility to set the low air loss mattress according to the resident's needs. During an interview on [DATE] at 10:15 a.m., LVN B said Resident #121 was admitted to the hospital yesterday ([DATE]) evening with a diagnosis of sepsis from the wound infection, and Resident #120 was admitted to the hospital for a wound infection not diagnosed yet with sepsis. During an interview on [DATE] at 10:30 a.m., ADON G said she was not wound care certified nor had she been certified by the wound care company to perform wound care in the facility. LVN G said she had not been checked off on wound care skills but was assigned to provide wound care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:24 p.m., ADON A she indicated she had been doing wound care in the facility for three weeks. ADON A said she had been a nurse [AGE] years but had never treated wounds such as pressure injuries. ADON A said she had not had a check off completed since being assigned wound care. ADON A said ADON G made rounds with the wound care physician on Thursday mornings and ADON G put the wound care orders in the computer. ADON A said during the period of [DATE] to [DATE] ADON G was responsible for the wound care for Resident #121. ADON A said she made ADON G aware Resident #121's wound was declining. ADON A said she was unaware of Resident #121's low air loss mattress not being set according to his current weight. ADON A said there was not a monitoring system for checking the low air loss mattresses. ADON A said she had not called the Wound Care Physician, the resident's doctor, nor the medical director. ADON A said she was responsible for the wound care for Resident #120. ADON A said Resident #120 did not have a low air loss mattress because he required a bariatric low air loss, and the facility did not have this mattress available. ADON A said the DON was made aware, but she was informed the facility did not have a contract with a durable medical equipment supply company to obtain a bariatric low air loss mattress therefore Resident #120 remained on the standard hospital bed mattress. During an interview on [DATE] at 3:35 p.m., the DON said she had visualized Resident #121's sacral wound and remembered the wound to be very small when he admitted . The DON said she did not remember any orders for Resident #121's wound care other than the one's implemented on [DATE]. The DON said she was unaware Residents #120 and #121missed wound care treatments. The DON said she was responsible for the implementation of the dietary recommendations, and she said she must have missed the orders for Resident #121. The DON said she did make rounds and saw the resident's wounds with the ADONs, and at that time she would stage the wounds. The DON said she ran a report on Mondays to show missed treatments. The DON said with missed wound care a resident could develop an infection and the infection could lead to death. The DON said she was unaware wound treatments were missed. During an interview on [DATE] at 8:52 a.m., the Medical Director said he had not seen the sacral wounds for Residents #120 and #121. The Medical Director said he was not made aware of the missed wound care for Residents #120 and #121 sacral wounds. The Medical Director said missed treatments to stage 4 pressure injuries were not acceptable and could cause a decline in the wound. During an interview on [DATE] at 9:36 a.m., Resident #121's Physician's Nurse indicated the physician had not been notified of the missed stage 4 sacral wound decline nor the missed treatments to the sacral wound. The Physician's Nurse said the hospital communicated with her concerning the wound condition. The nurse said she was informed by the hospital Resident #121's received debridement to the sacral wound on [DATE] and during the surgical procedure he went into A-fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and now required 5 liters of oxygen. During an interview on [DATE] at 4:39 p.m., with the Interim Administrator said he would expect the nurses to input the wound care orders in on admission, expected the wounds to be measured, expected the treatments to be implemented. The Interim Administrator said not receiving wound care could cause a wound to have a serious decline. 45879 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Record review of Resident #5's electronic face sheet, dated [DATE], revealed a [AGE] year old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue), sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death), anxiety (what we feel when we are worried, tense or afraid), high blood pressure, and Alzheimer's (a type of dementia that affects memory, thinking and behavior). Record review of Resident #5's quarterly MDS assessment, with an ARD of [DATE], revealed under Section B, Hearing, Speech, and Vision, was coded as a 0 indicating she understands and was understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 14 which indicated the resident was cognitively intact. Section G, Function Status, under section B indicated she needed extensive assistance with bed mobility, personal hygiene, total assist with transfers, dressing, bathing, and supervision with eating. Section M, Skin Condition, under section M1200 she received pressure ulcer/injury care and application of nonsurgical dressing during the look back period. Record review of Resident #5's comprehensive person-centered care plan, dated initiated [DATE], and revised on [DATE]. revealed the Focus indicted: Resident #5 was at risk for further skin breakdown, also had a wound to right, distal, lateral calf lower leg and pressure area to right ischium related to immobility, incontinence, and disease process. Intervention indicated: Keep physician and RP informed of my progress. During observation and interview on [DATE] at 9:02 a.m., Resident #5 was in her bed with her heels not floated and lying flat on top of one pillow. There was no wedge present to float the heels and no pressure relieving boots present. Resident #5 said she did not know what heel protectors were, but she had not had the boots on in a while. She said normally her feet were elevated. Record review of Resident #5's skin assessment completed on [DATE], did not reveal the 4 new pressure areas to right and left foot. It did indicate: Left Ischium stage 4 measuring 1.0X0.5X0.5cm, Right Ischium stage 4 measuring 3.0X0.4X0.2cm, Sacrum stage 3 measuring 3.0X2.7X0.3 and right ankle stage 4 measuring 3.0X0.5X0.1cm. In the comment box it indicated; New unstageable areas to feet, we will be using skin prep daily. Record review of Resident #5's wound care notes, dated [DATE] indicated: Site1, Left Ischium stage 4 measuring 1.0X0.5X0.5cm, Site2, Right Ischium stage 4 measuring 3.0X1.0X0.2cm, Site3, right calf stage 4 measuring 3.0X0.5X0.1cm and Site 6, Sacrum stage 3 measuring 3.0X2.7X0.3cm. Record review of Resident #5's [NAME] notes, dated [DATE], indicated the above wounds and 2 new areas: Site 7, Unstageable DTI of the right foot measuring 3.0X1.0cm. Site 8, Unstageable DTI of the left foot measuring 3.0X2.0cm. It did not reveal 4 new areas on [DATE] only 2 new areas. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #5's physician orders., Apply heel protectors to feet while in bed. 1) Apply skin prep once daily to unstageable DTI (deep tissue injury) on outer aspect of right foot, 2) Apply skin prep once daily to unstageable blister to inner left foot arch, 3) Apply skin prep once daily to unstageable DTI on inner aspects of left foot,4) Apply skin prep once daily to unstageable blister to inner aspect of right foot. Record review of Resident #5's wound care note, dated [DATE], indicated the following: Site 1,Left Ischium stage 4 measuring 0.8X0.5X0.5cm, Site 2,Right Ischium stage 4 measuring 2.0X0.4X0.2cm, Site 3,right ankle stage 4 measuring 0.2X0.1X0.1cm,Site 6, Sacrum stage 3 measuring 3.0X2.7X0.cm, Site 7, Unstageable DTI of the right foot measuring 2.0X1.0cm Site 8, Unstageable DTI of the left foot measuring 3. 0X2.0cm, Site 9, stage 2 pressure wound of left medial foot measuring 6.0X1.0X0.1cm, Site 10, unstageable ulcer on right foot with no measurements. Record review of Resident #5's treatment record, dated [DATE], indicated: the following treatment orders started [DATE]:. Apply skin prep once daily to unstageable blister to inner aspect of right foot. Apply skin prep once daily to unstageable DTI to outer aspect of right foot. Apply skin prep once daily to unstageable blister to inner left foot arch. Apply skin prep once daily to unstageable DTI on inner aspects of left foot. Record review of Resident #5's physicians orders dated [DATE] indicated an order for heel protectors to feet when in bed started on [DATE]. During an observation on [DATE] at 10:31 a.m., Resident #5 was observed in her bed watching television. Her heels were not floated and were lying flat on top of one pillow. There was no wedge present to float the heels and no pressure relieving boots present. During an observation and interview on [DATE] at 11:10 a.m., ADON G performed wound care on Resident #5, 4 dark purple areas which were not noted on the treatment sheet to left and right foot were observed. They presented as a deep tissue injury (DTI). The ADON G said those were identified last week on [DATE] on rounds with the Wound Care Doctor. ADON G said she forgot to add them last week on the treatment record because her computer was messed up. ADON G said without orders being on the treatment administration record (TAR), treatments could go untreated. During an observation on [DATE] at 12;25 p.m., ADON G measured Resident #5 other 2 new areas, presenting as DTI that were not on the [DATE] wound care notes, right side of foot at 2.0X2.0 cm and left inner top of foot at 3.0x2.0cm. During a phone interview on [DATE] at 9:24 a.m., Wound Care Doctor said Resident # 5 had 2 new identified areas to the right and left feet on today's rounds. He said they identified 2 other new areas to right and left feet last week on rounds but was not aware the treatment orders had not be implemented. The Wound Care Doctor said ADON G called him yesterday on [DATE] about the 2 new areas and orders were given. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on [DATE] at 5:23 p.m., Resident #5 was in her bed with heels floated with a wedge underneath her lower legs but no pressure relieving boots were present. During an observation and interview on [DATE] at 2:57 p.m., Resident #5 was in her bed with heel protectors on, but they hung off her feet. Resident #5 feet and toes were touching the footboar [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 33249 Based on observation, interview, and record review the facility failed to ensure the residents environment remained free of accident hazards by not adequately monitoring the proper storage of oxygen cylinders for 2 of 2 residents, (Resident #'s 16 and 40), proper transfer for 1 of 1 resident (Resident #38) and timely completion of smoking assessments for 1 of 1 resident (Resident #54). The facility failed to store oxygen properly for Resident # 40. The facility failed to ensure Resident #16 oxygen cylinder was properly secured. The facility failed to ensure Resident #38 was transferred using a gait belt. The facility failed to ensure Resident #54 had a smoking assessment completed quarterly. These deficient practices could place residents at risk of injury. Findings include: 1. Record review of a face sheet dated 01/13/2023 indicated Resident #38 was admitted on [DATE] and readmitted on [DATE] with the diagnosis of a stroke, generalized weakness, right sided paralysis following a stroke. Record review of the comprehensive care plan dated 12/13/2022 Resident #38 required assistance with his ADLs to maintain a sense of dignity by being clean, dry, free of odors, well groomed, and no measurable decline in transferring, bed mobility, ADL functional ability with the interventions of assessing risk factors for deterioration and elimination risks, assist with ADLS, and document and report any deterioration in status to the physician. During an observation and interviews on 01/10/2023 at 11:30 p.m., Resident #38 was assisted from his bed to the wheelchair by CNA P and LVN L. CNA P began transferring Resident #38 putting her arms underneath his arms, when Resident #38 legs become weak, and he started to go down, then LVN L assisted Resident #38 underneath one of his arms. CNA P said she should have used a gait belt to transfer Resident #38 because he could have fallen. CNA P had a gait belt around her waist. LVN L said today was the first time she had provided care to Resident #38, and she did not realize he was so week. LVN L said she should use a gait belt when transferring a resident. LVN L she should have looked at Resident #38's care plan prior to care for his transfer assistance needs. During an interview on 01/17/2023 at 1:55 p.m., the Regional Nurse Consultant said a gait belt should be used when transferring a resident. The corporate nurse the care plan should be used to determine a resident's transfer needs. The corporate nurse said the ADONs, and the DON were responsible for ensuring CNA checkoffs were completed. A request was made to the corporate nurse for CNA Woods skill check offs, but one was not provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/17/2023 at 4:55 p.m., the Interim Administrator said he expected nursing staff to use proper procedures when transferring a resident such as use of a gait belt. The Interim Administrator said the resident, or the staff could get injured with an improper transfer. 45879 2. Review of Resident #40's electronic face sheet dated 01/13/23 revealed she was admitted to the facility on [DATE] with diagnoses of respiratory distress (a serious lung condition that causes low blood oxygen), anxiety disorder (mental conditions characterized by excessive fear of or apprehension about real or perceived threats), high blood pressure, fluid overload (a condition where you have too much fluid volume in your body), and muscle weakness. Review of Resident #40's MDS assessment with an ARD of 01/04/23 revealed under Section B, Hearing, Speech, and Vision, she was coded as 0 indicated Resident #34 understands and was 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 supervision with bed mobility, transfers, dressing, eating and toileting. Section O, Treatments, Procedures, and Programs, under section 00100 indicated oxygen was used in last 14 days. Review of Resident #40's physicians order dated 01/13/23 indicated: may wear oxygen at 2 liters via nasal cannula continuously. Review of Resident #40's comprehensive person-centered care plan dated 03/25/21 when it was initiated, and it was revised on 09/09/22. Focus indicted: Resident #40 has the diagnosis of acute respiratory failure with hypoxia, acute respiratory distress syndrome and history of COVID-19 and has the potential for complication. Interventions: monitor for signs and symptoms of respiratory distress and report to physician as needed, monitor document report abnormal breathing patterns to MD, maintain a clear airway and administer medication as ordered. During an observation on 01/09/23 at 12:19 p.m., Resident #40 was sitting in her wheelchair next to bed with oxygen cylinder sitting next to entry door unsecure. During an observation on at 01/10/23 at 3:58 p.m., oxygen cylinder sitting beside canister holder in Resident #40's room. During an interview on at 01/10/23 at 4:20 p.m., CNA P observed Resident #40's oxygen cylinder next to wall unsecure. CNA P said she was not aware if oxygen cylinders could be in the room unsecure. CNA P said she would go ask the charge nurse to verify. During an interview on 01/10/23 at 4:26 p.m., ADON A observed an oxygen cylinder on the floor in Resident #40's room. ADON A said the oxygen cylinder should not be in the room unsecure. ADON A said failure to secure oxygen can be dangerous for everyone, it could explode. During an interview on 01/10/23 at 04:48 p.m., LVN L said oxygen cylinders should not be on the floor unsecure. LVN L said an unsecure oxygen cylinder could be dangerous for many reasons. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/17/23 at 2:06 p.m., RNC said she expected oxygen cylinders to be always secure in a canister or back of wheelchair holder. The RNC said the risk of oxygen cylinders being unsecure could lead to them falling over or blowing up related to compressed air. The RNC said she expected all staff to know oxygen cylinders should never be freestanding. 46310 Based on observation, interview, and record review the facility failed to ensure the residents environment remained free of accident hazards by not adequately monitoring the proper storage of oxygen cylinders for 2 of 2 residents, (Resident #'s 16 and 54), proper transfer for 1 of 1 resident (Resident #38) and timely completion of smoking assessments for 1 of 1 resident (Resident #54). The facility failed to ensure Resident #54 had a smoking assessment completed quarterly. These deficient practices could place residents at risk of injury. Findings include: 3. Record review of Resident #54's face sheet, dated 1/13/23, revealed the resident was [AGE] year old female who admitted to the facility on [DATE] (readmission 11/26/21) with diagnoses which included: chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), disorder of the arteries and arterioles (a buildup of fatty deposits in the arteries), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), hallucinations (an experience involving the apparent perception of something not present), and dependence on supplemental oxygen. Record review of Resident #54's Quarterly MDS assessment, dated 12/29/22, revealed the resident's BIMS score was 4, which indicated severe cognitive impairment. The resident required total dependence with locomotion off unit, extensive assistance with transfer, dressing, toilet use, and personal hygiene, and supervision for the tasks of locomotion on unit and eating. Record review of Resident #54's care plan, undated, revealed Resident #54 with a focused that indicated I am at risk for Respiratory infections/distress, Hypoxia, SOB, and cough related to DX of COPD and dependence on supplemental oxygen. I continue to want to go smoke once daily. I will immediately start desaturation, and this is very risky for me. Only a nurse can take me to smoke. I will be educated and encouraged to start cessation. I have agreed and will start smoking cessation by using nicotine patch. I can continue to ask to smoke even though my O2 saturation put me at great risk and am not using the patch. My O2 saturation low even with O2 and it is not safe to smoke, but I continue to ask. Hospice will not write an order to not smoke as this is a resident right, but nursing judgement is used here because if I smoke my O2 saturation drop to the 30's and this is detrimental to my health and safety. Nicotine addiction- I am a smoker: I have been assessed to be: Supervised smoker. A new focus indicated I smoke Traditional cigarettes. I had decided that would try nicotine patches to aid in quitting but have now decided I want to continue to smoke. Intervention for this focus is to complete smoking assessment as per facility policy, no Oxygen present while in smoking area, and will be aware & practice safe smoking techniques. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of electronic medical records for Resident #54 had a smoking assessment completed on, 3/19/21, 6/18/21, 9/18/21, and 12/18/21 no others smoking assessment dated [DATE], indicated that the resident is cognitive capable of making decision to smoke, the resident does not understand facility smoking policy due to diagnosis of dementia, resident has a history of smoking-related problems that would be hazardous to self or others because oxygen saturation while smoking. It further indicated the resident requires the supervision of a licensed nurse when smoking due to concerns with her oxygen saturation dropping, so the nurse can assist accordingly in such a situation. During observation and interview on 1/9/23 at 09:44 AM with Resident #54, she said that she required assistance from staff with smoking. She said the social worker had not talked to her about smoking. She said she was not involved in any care plan meeting about smoking. She said the staff do not take her to smoke and just inform her that a nurse will come soon. She said she had not been out to smoke today yet. She said she only wants to smoke one time a day and that is at the 10AM slot. During observation and interview on 1/10/23 at 11:47 AM with Resident #54, she said she asked a nurse to take her smoking during the 10 AM smoking slot but no one ever came. During observation and interview on 1/11/23 at 02:34 PM with Resident #54, she was observed in observed in the lobby area near the nurse's station. She said she was waiting to go for a smoke break and has been waiting since 10 AM. She said she asked nursing staff, and no one has taken her. During observation and interview on 1/12/23 at 11:12 AM with Resident #54, she was observed in bed watching TV. She said she had been out to smoke earlier, but she cannot remember who had taken her to do so. During interview on 1/9/23 at 9:57 AM with LVN L, she said she was told from DON that Resident #54 is no longer allowed to smoke due to oxygen saturation decreasing. She said she is aware that the resident if free to make her own decision about smoking. She said the social worker was responsible for completing the smoke assessment. During interview on 1/17/23 at 1:54 PM with LVN O, she said nursing staff do not complete smoking assessment. She said the social worker was responsible for getting those completed. She said she was not sure if Resident #54 has had one completed. She said she would not normally check a smoking assessment and that either DON or social worker would inform them of any changes in the resident. During interview on 1/13/23 at 1:13 PM with the Social Worker, she said she was responsible for completed smoking assessment on all smoking residents. She said she was aware that Resident #54 was a smoking resident even though she was not listed on the smokers list provided by facility. She said Resident #54 only smokes about once a day. She said she could not locate a resident smoking assessment for Resident #54, but she would complete one today. She said she was not aware that it was overdue because she is a new social worker to the facility. She the assessment informed staff of the type of care that is needed for the resident for smoking and what the parameters of that care is. She said Resident #54 must have a nurse with her during smoking times due to her oxygen saturation decreased. She said Resident #54 has been prescribed a nicotine patch but refuses to allow staff to place it on her. She said the risk to residents if a smoking assessment was not conducted on admission, quarterly or any time there is a change of condition was that they could have accidents or burn themselves or others. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 1/17/23 at 4:22 PM, with the Regional Corporate Nurse who said she expects staff to complete a smoking assessment according to facility policy which is on admission, if applicable, quarterly, and/or if there was a change of condition. She said the person responsible for this task is the social worker. She said she was not aware that Resident #54 had not had a smoking assessment conducted since 12/21. Record review of the undated facility smoking policy, revealed 18. Smoking assessment will be completed on admission, quarterly, and as needed only on residents who use tobacco and E-cigarette . 46928 4. Record review of a face sheet dated 01/11/23, indicated Resident #16 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of diabetes (chronic condition that affects the way the body processes blood sugar), end stage renal disease (kidneys cease functioning on a permanent basis), and high blood pressure. Record review of the quarterly MDS assessment dated [DATE], indicated Resident #16 was usually understood and usually understood others. The MDS revealed Resident #16 BIMS score was a six, indicating she had severe impaired cognition. The MDS indicated Resident #16 required supervision with transfers, locomotion, dressing and toileting. Resident #16 required limited assistance with bed mobility, eating, and personal hygiene and extensive assistance with bathing. The MDS under Section O (Special Treatments, Procedures, and Programs) did not have oxygen therapy checked as being received. Record review of the other summary report dated 01/11/23 did not reveal Resident #16 had an order for oxygen. During an observation on 01/09/23 at 10:15 AM, Resident #16 had an oxygen cylinder in a wheelchair sleeve freestanding at the corner of the left side of her room. Resident #16 was not in the room. During an observation on 01/09/23 at 03:54 PM, Resident #16 continued to have the oxygen cylinder in the corner of the left side of the room. Resident #16 was not in the room. During an observation and interview on 01/10/23 at 4:25 PM, Resident #16 continued to have an oxygen cylinder in a wheelchair sleeve freestanding at the corner on the left side of her room. LVN H said the oxygen cylinder should not be left freestanding because it can be dangerous for the resident if it falls over it can explode. LVN H said the oxygen cylinder should be secured behind the wheelchair or on a rolling stand. LVN H indicated everyone was responsible for ensuring the oxygen cylinders are properly secured. During an interview on 01/17/23 at 12:51 PM, ADON A said she expected the oxygen cylinders to be properly secured on the wheelchair or in a rolling stand. ADON A said the oxygen cylinders should not be freestanding as they can fall over and explode which can therefore cause serious harm to the residents. During an interview on 1/17/23 at 1:57 PM, the RNC said she expected the oxygen cylinders to be properly secured. The RNC said if the oxygen cylinder was knocked over it could cause serious harm to the residents. The RNC said she expected everyone that goes in and sees it should be able to tell that it needs to be secured. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/17/23 at 5:00 PM, the Interim Administrator said he expected the oxygen cylinders to be stored in the oxygen storage room so they will not get knocked over. Record review of the facility's policy titled Oxygen Safety dated 12/01/22 indicated .the policy of this facility is to provide a safe environment for resident's staff, and the public .Cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty .when small-size (A,B,D, or E) cylinders are in use, they shall be attached to a cylinder stand or to a medical equipment designed to receive and hold compressed gas cylinders . Record review of a Safe Lifting and Movement of Residents policy dated July 2017 indicated in order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 2. Manual lifting of residents shall be eliminated when feasible. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to maintain acceptable parameters for nutritional status such as usual body weight or desirable body weight range by failing to provide nutritional and hydration care and services to residents consistent with the resident's comprehensive assessment for 4 of 21 Residents reviewed for weight loss. (Resident #'s 32, 38, 119, 220) 1.The facility did not address Resident #32's weight loss of 12.7-pounds in one month. 2.The facility failed to provide Resident #32 her magic cup (nutritional ice cream) with lunch and dinner meals. The facility failed to have the dietician to address Resident #32 weight loss. 3.The facility did not address Resident #38's weight loss of 35 pounds since admission on 11/18/2022. 4.The facility did not obtain an admission weight for Resident #119. The facility did not address Resident #119's weight loss of 30 pounds. 5.The facility failed to ensure Resident #220 received an accurate weight upon admission or within the two weeks following. 6. The facility failed to implement dietician recommendations timely for Resident #220. An Immediate Jeopardy (IJ) situation was identified on 01/13/2023 at 1:20 p.m. While the IJ was removed on 01/17/2022, the facility remained out of compliance at a scope of a pattern with the severity of potential for 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 could place residents at risk for decreased nutritional status, decline in health, serious illness, or hospitalization . Findings included: Record review of the CMS 672, dated 01/09/2023, indicated in Section G, other. F140 1 resident with unplanned significant weight loss/gain. 1). Record review of Resident #32's face sheet, dated 1/13/2023, 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 01/13/2023 indicated Resident #32 had a diet order of mechanical soft and nectar thickened fluids dated 02/05/2022, and a magic cup with lunch and dinner dated 09/06/2021. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #32's computerized weights indicated her weight was 153.8 pounds on 12/09/2022 and 141.1 pounds on 01/06/2023. Record review of a comprehensive care plan dated 04/08/2023 and revised on 05/03/2021 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 02/16/2023. 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 04/08/2021. The interventions included administer snacks, and supplements as ordered, and provide a magic cup with lunch and dinner dated 07/07/2021. 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. Record review of a weight record dated 01/13/2023 indicated Resident #32's 180 days prior was 151.8 pounds., 90 days prior weight was 152.8 pounds., and on 01/06/2023 Resident #32's weight was 141.1 pounds. Record review of the dietician reports revealed the following: -On *10/22/2022, there was: no mention of recommendations for weekly weights for Resident #32. -On *11/11/2022, there was: no mention of recommendations for weekly weights for Resident #32. -On *11/30/2022, there was: no mention of recommendations for weekly weights for Resident #32. -On *12/10/2022, there was: no mention of recommendations for weekly weights for Resident #32. - On *12/18/2022, there was: no mention of recommendation for weekly weights for Resident #32. On *01/08/2023 and 01/09/2023, there was: no mention of recommendations for weekly weights for, Resident #32. During observations on 01/10/2013 - through 01/11/2023 for Resident #32 revealed the following: -On *01/10/23 at 12:55 p.m., there was no supplement with the Resident #32's lunch meal. -On *01/10/2023 at 5:55 p.m., there was no magic cup with her Resident #32's evening tray. - On *01/11/2023 at 12:25 p.m., there was no magic cup with her Resident #32's lunch tray. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-On *01/11/2023 at 6:00 p.m., there was no supplement with her Resident #32's evening tray. During an interview with the DON on 01/11/2023 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 logs the weight obtained. The DON said when she reviews the weights, she stars them for a reweight to verify. The DON said the hospital weights were often not correct therefore it was important to have a weight. Record review of the undated dietary supplement list, there were no residents receiving a magic cup at lunch or dinner. 2) Record review of Resident #38's face sheet, dated 1/13/2023, 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 1/13/23 indicated Resident #38 did not have a diet ordered. Resident #38 had orders in a que including the diet order waiting for processing. Record review of Resident #38's comprehensive care plan dated 11/29/2022 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 weights indicated his weight on 11/18/2022 was 225 pounds, his weight on 11/29/2022 was 200 pounds, his weight on 12/17/2022 was 242 pounds, and on 01/06/2023 was 190 pounds. Record review of a dietician progress note dated 11/30/2022 indicated Resident #38 weight was 200.0 pounds with a height of 73 inches. The dietician's note indicated Resident #38 had a regular diet with thin liquids, he could feed himself with supervision. The goal of the recommendations was he would maintain weight without a significant change. And the recommendations were to continue the diet. Record review of a dietician's consultant, dated 11/30/2022, indicated Resident #38 had no recommendations even though the weights indicated he had already lost 25 pounds. Record review of a dietician's consultant report dated 12/10/2022 indicated Resident #38 was not evaluated. Record review of a dietician's consultant report dated 12/18/2022 indicated Resident #38 was not evaluated. Record review of a dietician's consultant report dated 01/08/2023 indicated Resident #38 was not evaluated. During an observation on 01/09/2023 at 1:05 p.m., Resident #38 was eating lunch in his room. Resident #38 remains on isolation precautions for C-diff, an infection causing profuse diarrhea. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 01/10/2023 at 1:15 p.m., Resident #38 was eating lunch while lying in his bed. Record review of a dietary profile dated 01/11/2023 indicated Resident #38 was receiving a regular diet with no dietary supplements. 3) Record review of a face sheet dated 01/11/2023 indicated Resident #119 was an [AGE] year-old female who admitted on [DATE] with the diagnoses of 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 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 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 12/19/2022 indicated on 12/14/2022 Resident #119's weight was 160 pounds, and her height was 62 inches. Record review of a Dietary Profile dated 12/28/2022 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 01/06/2023 of 130 pounds. Record review of a Dietician Progress Note dated 01/08/2023 indicated Resident #119 was eating 50-75 % 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 Recommendation indicated on 01/08/2023 Resident #119 had no recommendations. Record review of the comprehensive care plan dated 01/10/2023 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 01/10/2022 Resident #119 had consumed 50 % of her meal while in her bed. Record review of the consolidated physician's orders dated 01/11/2022 indicated Resident #119's diet was a regular diet with thin liquids started 12/19/22. 46310 (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Record review of Resident #220's face sheet, dated 1/13/23, revealed the resident was [AGE] year old male who admitted to the facility on [DATE] with diagnoses which included: chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), sepsis (the body's extreme response to an infection), Type 2 diabetes mellitus without complications (an impairment in the way the body regulates and uses sugar (glucose) as a fuel), peroration of intestine (a loss of continuity of the bowel wall), paroxysmal atrial fibrillation (terminates spontaneously or with intervention within seven days of onset), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and acute cystitis without hematuria (a sudden inflammation of the urinary bladder). Record review of Resident #220's Quarterly MDS assessment was not completed and was not due according to admitted . Record review was attempted of Resident #220's baseline care plan but one was not completed. No comprehensive care plan was due according to admitted . Record review of Dietary consult visit dated, 1/8/23, for updated nutritional assessments. It was recommended that Resident #220 his tube feeding, Glucerna, be increased 650 ML per hour from 500 ML per hour, as prescribed on discharge summary, and water increased to 35 ML per hour from 20ML per hour, as prescribed on discharge summary. Dietician requested accurate height and weight be completed as none was available. Record review of hospital discharge documents dated 12/29/22 indicated Resident #220 weighted 90.5 Kg (199.52 pounds) on 12/29/22, date of discharged . Record review of weight check on 1/11/23 indicated Resident #220 weighed 164.8 for a total weight loss of 34.3 (17.40 percent). This showed significant weight loss in less than a 30-day period . During observation on 1/9/23 at 5:45 p.m., Resident #220 was asleep in his bed. The head of the bed was elevated, and he was receiving his tube feeding via pump . The pump read 500 ML per hour of Glucerna and 20ML per hour of water. During observation of weight check for Resident #220 on 1/11/23, CNA S conducted an in-bed weight and the scale indicated, 164.8. During observation and interview on 1/11/23 at 09:49 AM with Resident #220, he said he was new the facility and was just placed back on the regular floor. He said he contracted COVID-19. He said he had not been weighed when he arrived. He said he was weighed, maybe a day ago. He said he was unsure if he has lost any weight. He said he received his food through tube feeding placed while in the hospital prior to his admission. He said he has not seen anyone that said they was a dietician or nutritionist. During observation of weight check for Resident #220 on 1/13/23, CNA S conducted an in-bed weight and the scale indicated, 162.4. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview on 1/13/23 at 3:57 PM with CNA S, she said the DON usually had her to complete the weights weekly or monthly for residents. She said she knew she had to weigh new admits four times weekly and then it depended on if they have had any issues if she had to continue. She said she must weigh all residents at the beginning of the month. She said the weights must be done before the dietitian visits for the month. She said when she completed all the weights, she gave them to the DON, and usually within the next few days she would ask her to re-weigh a resident if needed. She said the DON entered all the weights into the electronic medical records, to her knowledge, after they have been reviewed and corrected. During an interview on 01/12/2023 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, or accidents. During an interview on 01/17/2023 at 1:36 p.m., LVN L indicated residents should be weighed on admission. 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 01/17/2023 at 2:39 p.m., the Regional Nurse Consultant indicated she was unaware of weight loss issues. The corporate nurse indicated 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 corporate nurse indicated there was not a reason for the admission or weekly weights not being obtained. During an interview on 01/17/2023 at 4:55 p.m., the Interim Administrator indicated the physician should be notified when the resident's weight falls in the parameter areas 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 07/01/2022 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Weight Monitoring policy dated 07/01/2022 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. These were determined to be an Immediate Jeopardy (IJ) on 01/13/2023 at 1:20 p.m. The Administrator was notified on 01/13/2023 at 1:20 p.m. that an Immediate Jeopardy (IJ) was identified due to the above failures. The Administrator was provided with the IJ template The IJ template was provided on 01/13/2023 at 1:25 p. m. The following Plan of Removal submitted by the facility. The plan of removal for F692 was accepted on 01/15/2023 at 5:16 p.m. and included the following: Weight: Residents at the care center reweighed to compare to January weights by DON, ADON, and transportation aide completed 01/14/2023: verified by record review of weekly weight logs. Any significant increase or decrease in weight addressed by notifying MD, dietician, and family. DON made notifications completed by 01/14/2023; verified by record review of resident printed orders. Any identified increase or decrease in weight was placed on weekly weights x 4 weeks and or until weight has been stabilized or until MD orders discontinue. Completed on 01/14/2023: verified by record review of the weekly weight log. Any new orders implemented immediately by licensed care staff. Completed 01/14/2023: verified by record review of the printed physician's orders. Admitting nurse or CNA will obtain admission weights with follow up by the ADON within 24 hours. Admission will have weekly weights x 4 weeks or until stable weights. Monitoring by DON, ADON, and MDS to prevent further systemic failure. Record review of weekly weight variance record dated 1/14/23 indicated 19 residents had weight variances identified. Record review of the physician orders indicated the physician had implemented supplements, dietician referrals, and weekly weight monitoring. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of in-service training report dated 1/12/23 indicated to implement all orders in a timely manner. 1. Dietary, Wound consultant treatments, and any other orders must implemented in a timely manner. 2. Orders must coincide with treatment and carried out as ordered. Interviews on 01/17/23 from 5:00 p.m. until 5:48 p.m. the surveyor confirmed the facility implemented their plan of removal. Interviews with 3 (6am-6pm) nurses LVN B, LVN D and LVN R, 2 (6pm-6am) nurses LVN U and LVN HH , said they were in-serviced on obtaining weights on admission then every week for 4 weeks or stable, reporting weight changes to the physician. Interviews with 4 CNAs (6am-6pm) CNA FF, CNA GG, CNA D, and 4 CNAs (6pm-6am) CNA MM, CNA OO, CNA PP and CNA LL indicated they were in-serviced on obtaining weights on admission. The CEO and interim Administrator were informed the Immediate Jeopardy was removed on 01/17/23 at 6:16 p.m. The facility remained out of compliance at a severity level of potential for harm that is not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview and record review, the facility failed to ensure respiratory care was provided consistent with professional standards of practice for 3 of 20 residents reviewed for respiratory care. (Resident #51, Resident# 35, Resident #36). The facility did not ensure Resident #51's oxygen concentrator filters was free from gray like substances. The facility failed to date the oxygen tubing for Resident #35 and Resident #36. The facility failed to provide oxygen concentrator filters for Resident #35, and Resident #36. These failures could place residents who required respiratory care at risk for respiratory infections. 1.Record review of the face sheet dated 01/13/23 indicated Resident #51 was [AGE] years old female admitted [DATE] and readmitted [DATE] with diagnoses of Left hip fracture, high blood pressure, atrial fibrillation (abnormal heartbeat) and muscle weakness. Record review of the MDS assessment dated [DATE] for significant change of status indicated Resident #51 in section B was usually understood and usually understood others. The BIMS (Brief Interview for Mental Status) was a 15 indicated Resident #51 was cognitive intact. The MDS in section G indicated Resident #51 required supervision with bed mobility, transfers, eating, transfers, and person hygiene and extensive assist with bathing. Section O, Special Treatments, Procedures, and Programs, under section 00100 did not indicate oxygen therapy. Review of Resident #51's physician's orders dated 01/13/23 indicated, Change respiratory tubing, mask, bottled water, clean filter every 7 days on Sunday night. Review of Resident #51's physician's orders dated 01/13/23 indicated, Oxygen at 2 liters at bedtime. Review of Resident #51's comprehensive person-centered care plan dated 04/14/20 when it was initiated, and it was revised on 09/11/22. Focus indicted: Resident #51 was at risk for shortness of breath related to decreased energy and fatigue. Intervention: Apply medication, oxygen and administer nebulizer treatments as ordered by physician. During an observation on 01/09/23 at 12:26 p.m., Resident #51 was in his room sitting in his wheelchair. Resident #51's oxygen concentrator filter noted with gray like material. During an observation on 01/10/23 at 4:21 p.m., Resident #51's oxygen concentrator filter noted with gray like material. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/13/23 at 4:51 p.m., LVN N observed Resident #51's oxygen filter with gray like material. LVN N said filters are supposed to be cleaned on Sunday night. LVN N said failure to clean filters could cause respiratory failure and infection. 2. Record review of Resident #35's electronic face sheet, dated 01/13/23, revealed an [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. Section O, Special Treatments, Procedures, and Programs, under section 00100 did not indicate oxygen therapy. Review of Resident #35's physician's orders dated 01/13/23 indicated, Change respiratory tubing, mask, bottled water, clean filter every 7 days on Sunday night. Review of Resident #35's physician's orders dated 01/13/23 indicated, Oxygen at 2 liters as needed. Review of Resident #35's comprehensive person-centered care plan dated 08/26/19 when it was initiated, and it was revised on 09/20/22. Focus indicted: Resident #35 was at risk for shortness of breath, chest pain, increased edema .related to congestive heart failure. Intervention: Apply oxygen and administer nebulizer treatments as ordered and monitor for effectiveness. During an observation on 01/09/23 at 9:40a.m., Resident #35 was sitting in her recliner with oxygen on. Resident #35 had oxygen tubing connected to her concentrator and located on back of her wheelchair. Resident #35 had neither oxygen tubing dated nor a concentrator filter. During an observation on 01/10/23 at 9:13 a.m., Resident #35 was sitting in her wheelchair with oxygen tubing not dated or bagged. Resident #35 did not have a filter on her concentrator. During an observation and interview on 01/10/23 at 4:59 p.m., LVN K, observed Resident #35 's oxygen tubing on floor, not bagged, no date and no filter on concentrator. LVN J said oxygen tubing should be changed and dated on Sunday nights. LVN J said the tubing should be dated and filters rinsed out weekly for infection reasons. During an observation on 01/11/23 at 9:15 a.m., Resident #35's oxygen tubing on floor and no filter on concentrator. 3.Review of Resident #36's electronic face sheet dated 01/13/23 revealed an [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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #36's quarterly MDS assessment with an ARD of 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 for moderately impaired cognition. Section G, Function Status, under section B indicated he needed supervision with transfers and toileting. Section O, Special Treatments, Procedures, and Programs, under section 00100 did not indicate oxygen therapy. Review of Resident #36's physician's orders dated 01/13/23 indicated, Change respiratory tubing, mask, bottled water, clean filter every 7 days on Sunday night. Review of Resident #36's physician's orders dated 01/13/23 indicated, Oxygen at 2 liters as needed. Review of Resident #36's comprehensive person-centered care plan with target date of 12/28/22 did not reveal a care plan for oxygen. During an observation on 01/09/23 at 10:41 a.m., Resident #36 was sitting in his recliner with oxygen on at 2 liters. Resident #36 oxygen tubing had no date and no filter noted on concentrator. During an observation on 01/10/23 at 9:33 a.m., Resident #36 was sitting in his recliner with oxygen on at 2 liters via nasal cannula. Oxygen tubing noted with no date and no filter noted on concentrator. During an observation and interview on 01/11/23 at 4:28 p.m., LVN L went into Resident #35's and Resident#36's room and verified neither had dates on their oxygen tubing or filters on their concentrators. LVN L said they both should have filters on their concentrators for infection reasons. LVN L said she did not have any filters but would have maintenance to replace. During an interview on 01/16/23 at 6:40 p.m., LVN X said they clean filters, change the oxygen/HHN tubing on Sunday nights and date the tubing. LVN X said this was done to prevent infection and respiratory issues. During an interview on 01/17/23 at 2:06p.m., the RNC said she expected oxygen tubing to be changed weekly and dated and bagged when not in use and concentrator filters to be cleaned weekly and as needed. The RNC said failure to change or keep clean could lead to respiratory infection. The RNC said the ADON's should be monitoring to make sure oxygen, HHN and filters are changed or cleaned. During an interview on 01/17/23 at 2:30p.m., RNC said they did not have a policy on respiratory care. During an interview on 01/17/23 at 5:00p.m., the interim administrator said he expected charge nurses to follow physicians' orders on respiratory equipment. The interim administrator said the administrative nurses to follow up and failure to follow could cause respiratory issues.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to ensure dialysis services were provided consistently with professional standards of practice for 1 of 1 resident (Resident #16) reviewed for quality of care. The facility failed to keep ongoing communication with the dialysis facility for Resident #16. This failure could place the residents, who received dialysis, at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Record review of a face sheet dated 01/11/23, indicated Resident #16 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of diabetes (chronic condition that affects the way the body processes blood sugar), end stage renal disease (kidneys cease functioning on a permanent basis), and high blood pressure. Record review of the quarterly MDS assessment dated [DATE], indicated Resident #16 was usually understood and usually understood others. The MDS revealed Resident #16 BIMS score was a six, indicating severe impaired cognition. The MDS indicated Resident #16 required supervision with transfers, locomotion, dressing and toileting. Resident #16 required limited assistance with bed mobility, eating, and personal hygiene and extensive assistance with bathing. The MDS under Section O (Special Treatments, Procedures, and Programs) had dialysis checked. Record review of the other summary report dated 01/11/23 revealed Resident #16 had an order to transport to dialysis center on Monday, Wednesday, and Friday via facility van. Record review of the comprehensive care plan dated 03/30/22 indicated Resident #16 had impaired renal function, received dialysis three times a week, and was at risk for shortness of breath, chest pain, and infection to shunt site. The care plan had interventions to monitor the resident's condition pre and post dialysis and report abnormalities to the medical director. Record review of the Resident #16's dialysis communications sheets revealed the facility had not completed the upper portion of the dialysis communication sheet which included the resident's vital signs, condition, or new orders prior to leaving the facility for the following dates: *12/21/22 *12/23/22 *12/26/22 *12/28/22 *12/30/22 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*01/02/23 *01/04/23 *01/06/23 *01/09/23 *01/11/23 During an interview on 01/13/22 at 08:53 AM, LVN H indicated that she completes the upper portion of the dialysis communication prior to Resident #16 leaving for dialysis and she places it at the nurse's station for transport to get. LVN H said transport does not always get them. During an interview on 1/13/23 at 03:18 PM, the RN at the dialysis clinic said she has not been receiving the dialysis communication consistently from the facility. During an interview on 01/13/23 at 05:34 PM, LVN N said the charge nurse for Resident #16 was responsible for completing the upper portion of the dialysis communication sheet prior to resident leaving for dialysis. LVN N said the vital signs, medications taken that morning and any medications due at dialysis should be filled out. LVN N said by not filling out the dialysis communication sheet could place the resident at risk for being placed on the dialysis machine, have an adverse reaction, and die. During an interview on 01/17/23 at 11:38 AM, LVN O said she does not send a dialysis communication form every time Resident #16 leaves for dialysis. LVN O said by not completing the dialysis form, the resident could be risk for having her blood pressure drop during dialysis treatment if the facility was not aware her blood pressure had been low prior to treatment. During an interview 01/17/23 at 12:51 PM, ADON A said she expected the dialysis communications sheet be filled out prior to each dialysis treatment and given to the transport personnel. ADON A said the risks for not completing the dialysis communication prior to dialysis treatment and noting any changes the resident had, could cause Resident #16 to have complications during dialysis treatment. During an interview on 01/17/23 at 01:57 PM, RNC said she expected the facility nurse to fill out the top portion of the dialysis communication sheet prior to Resident #16 leaving for dialysis. RNC said by not completing the dialysis sheet, the resident was at risk for a poor outcome during treatment if the resident was having issues prior to treatment and the dialysis clinic was not aware of them. During an interview on 01/17/23 at 05:00 PM, the Interim Administrator said he expected the dialysis communication sheet be filled out for each dialysis resident. The Interim Administrator said by not completing the sheet will cause each facility to not be informed of the resident's health status. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Hemodialysis dated 07/01/22 indicated . The facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychological needs of the residents receiving hemodialysis .the licensed nurse will communicate to the dialysis facility telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limited itself to: timely medication administration (initiated, held, or discontinued) by the nursing home and or/dialysis. Physician/treatment orders, laboratory values, and vital signs .changes and/or decline in condition unrelated to dialysis

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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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Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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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 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,

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review the facility failed to ensure that residents were free of significant medication errors for 1 of 6 residents reviewed for medication pass. (Resident #25) LVN H failed to ensure Resident #25 received her Keppra (medication used for seizures) as ordered by the physician. This failure could place the resident at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: Record review of a face sheet dated 01/13/23 indicated Resident #25 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of stroke, gastrostomy (tube inserted in stomach for nutrition and medications), seizures, and high blood pressure. Record review of the most recent quarterly MDS dated [DATE] indicated Resident #25 was usually understood and usually understood others. The MDS revealed Resident#25 BIMS score was a two, indicating severe cognitive impairment. The MDS indicated Resident #25 required extensive assistance with bed mobility, transfers, and dressing. Resident #25 was totally dependent on locomotion, eating, toileting, and bathing. The MDS revealed under section I, Active Diagnoses, had seizure disorder or epilepsy checked. Record review of the order summary report dated 01/13/23 indicated Resident #25 had an order for levetiracetam (Keppra) 100mg/ml solution give 5 milliliters via peg-tube four times a day for seizures with a start date of 02/18/2022. Record review of the comprehensive care plan dated 06/06/21 with a revision date of 03/31/22 indicated Resident #25 was at risk for injury related to seizure disorder, receiving anti-convulsant medications, and was at risk for side effects from the medication which included adverse reactions and toxicity. The goal for Resident #25 was she would not exhibit signs and symptoms of side effects, adverse reactions, or toxicity to medications. The care plan intervention indicated to administer medications as ordered. During an observation of medication administration on 1/10/23 at 09:18 AM, LVN H poured 10 milliliters of Keppra liquid in graduated medicine cup. LVN H administered the medication to Resident #25 via her gastrostomy tube (tube inserted in stomach for nutrition and medications). During an interview on 01/13/23 at 8:53 AM, LVN H indicated she administered more than the prescribed dose of Keppra. LVN H, after reviewing Resident #25 physician orders, said she should have administered 5 milliliters of Keppra solution as ordered by the physician. LVN H said Resident #25 was at risk for having her Keppra level elevated due to receiving the double dose of medication . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/23 at 2:17 PM, LVN H indicated the rights of medication administration included the right patient, right medication, right dosage, and right time. During an interview on 01/17/23 at 1:57 PM, the RNC indicated she expected medications to be given as ordered by the physician. The RNC said by not following physician orders, the resident could be at risk for receiving the wrong dose. During an interview on 01/17/23 at 5:00 PM, the Interim Administrator said he expected medications to be administered as ordered. The Interim Administrator said by not following the physicians orders the resident was at risk for adverse side effects. He said the DON and administrative nurses were responsible for ensuring the medications are administered as ordered. Record review of the facility's policy titled Administering Medications revised in April 2019, indicated . medications are administered in accordance with prescriber orders, including any required time frame.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of the 3 medication carts reviewed for medications storage. (Halls 5/3 nurse's cart and halls 1/2 nurse/medication cart) 1. The facility failed to ensure Resident #63's two Lantus pens and one Humalog pen were dated when opened on halls 5/3 nurse's cart. 2. the facility failed to ensure Resident # 53's Lantus vial was dated when opened on hall 5/3 nurse's cart. 3. The facility failed to remove Resident #46's expired tramadol from the halls 5/3 nurse's cart. 4. The facility failed to remove Resident #40's expired fluticasone nasal spray from halls 1/2 nurse/medication cart. 5. The facility failed to remove the expired hemorrhoidal ointment from the halls 1/2 nurse/medication cart. These failures could place residents at risk for not receiving the therapeutic benefit of medications, adverse reactions to medications, or harm by indigestion. Findings include: 1. Record review of Resident #63's face sheet, dated 01/22/23, indicated a [AGE] year old male who was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar), chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), hypertension (force of the blood against the artery walls is too high), chronic systolic congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). Record review of Resident #63's admission MDS, dated [DATE], indicated he was understood and understood others. Resident #63 had a BIMS score of 12, which indicated he had mildly impaired cognition. Resident #63 required supervision with all ADLs. Section N0350, Insulin, indicated Resident #63 received insulin injections seven times during the last seven days. Record review of Resident #63's order summary report, dated 01/11/23, indicated he had the following orders: *Humalog solution 100 unit/ml (insulin lispro) inject 33 units subcutaneously before meals and at bedtime related to Type 2 diabetes mellitus with an order date of 01/06/23. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Lantus Solostar solution pen-injector 100unit/ml (insulin gargline) inject 90 units subcutaneously two times a day for diabetes with an order date of 10/01/22. During an observation on 01/10/23 at 2:48 PM, the halls 5/3 nurse's cart revealed Resident #63's two Lantus insulin pens and one Humalog pen were opened and did not have an opened date on them. 2. Record review of Resident #53's face sheet, dated 01/11/23, indicated a [AGE] year old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar), weakness, hypertension (force of the blood against the artery walls is too high), depression (mood disorder that causes persistent feeling of sadness or loss of interest), and dementia (memory loss). Record review of the Resident #53's annual MDS assessment, dated 11/1/22, indicated she was understood and understood others. Resident #53's had a BIMS score of 10 which indicated she had moderately impaired cognition. Resident #53 required limited assistance with bathing and supervision with all other ADLs. Section N0350, Insulin, indicated Resident #53 received insulin injections seven times during the last seven days. Record review of Resident #53's order summary report, dated 01/11/23, indicated she had an order for Lantus solution 100 unit/ml (insulin glargine) inject 90 units subcutaneously at bedtime for diabetes with an order date of 09/11/22. During an observation on 01/10/23 at 2:48 PM, halls 5/3 nurse's cart revealed Resident #53's Lantus vial was opened and did not have an opened date. 3. Record review of Resident #46's face sheet, dated 01/11/23, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (memory loss), anxiety, depression (mood disorder that causes persistent feeling of sadness or loss of interest), and hypertension (force of the blood against the artery walls is too high). Record review of Resident #46's quarterly MDS dated [DATE] indicated she was usually understood and usually understood others. Resident #46's BIMS score was a five, which indicated she had severe cognitive impairment. Resident #46 required extensive assistance with bed mobility, transfer, locomotion, toileting, and personal hygiene. Resident #46 was totally dependent on dressing and bathing. Section J0100, pain management, did not indicate resident received scheduled pain medication or as needed pain medication within the last 5 days. Section J0300, Pain presence, indicated Resident #46 did not have pain within the last 5 days. Section N0410, medications received, did not indicate Resident #46 received opioid medication within the last seven days. Record review of Resident #46's order summary report dated 01/11/23 indicated an order for tramadol 50mg tablet give 50mg by mouth every six hours as needed for moderate-severe pain with an order date of 06/13/22. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/10/23 at 2:48 PM, halls 5/3 nurse's cart revealed Resident #46's expired tramadol with an expiration date of 10/26/22. LVN H said the insulin was not good after 30 days of being out of the refrigerator. LVN H said by not knowing when the insulin was opened, the medication could not be sufficient for the blood sugar. LVN H said it was nurses' responsibility to make sure the insulin was dated when opened and to check the cart for expired medications. LVN H said the carts should be checked daily. 4. Record review of Resident #40's face sheet dated 01/11/23 indicated an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included unspecified protein calorie malnutrition (disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food), weakness, anxiety, and hypertension (force of the blood against the artery walls is too high). Record review of Resident #40's quarterly MDS dated [DATE] indicated she was understood and understood others. Resident #40 had a BIMS score of 12, which indicated, mildly impaired cognition. Resident #40 was totally dependent on bathing and required supervision for all other ADLs. Record review of Resident #40's order summary report dated 01/11/23 indicated an order for Flonase suspension 50mcg/act (fluticasone propionate) two sprays in each nostril every 24 hours as needed for allergies with an order date of 11/23/21. During an observation and interview on 01/10/23 at 3:10 PM, hall 1/2 nurse/medication cart revealed Resident #40's expired fluticasone nasal spray with the expiration date of 12/21/22 and an over-the-counter expired hemorrhoidal ointment with the expiration date of 08/21. LVN L said the cart should be checked at least monthly for expired medications. LVN L said the resident could be at risk for receiving an expired medication and it would not be effective. LVN L said expired medications are placed in the discontinued box in the medication room. During an interview on 01/17/23 at 12:51 PM, ADON A said she expected the carts to be checked weekly for expired medications. ADON A said expired medications should be taken off the cart and placed in the discontinued bin in the medication room. ADON A said she expected the nurse to date the insulin when first opened because some insulins are only good for 28 days. ADON A said by dating the insulin they will know when it needed to be replaced. ADON A said the resident would be at risk for receiving an expired medication and not be effective. During an interview on 01/17/23 at 1:57 PM, the RNC said she expected the expired medications to be pulled off the cart and destroyed. The RNC said the nurses were responsible of ensuring there were no expired medications on the cart by checking the medications during their medication pass. The RNC said she expected the nurse who first opens the insulin to date it when opened. The RNC said resident was at risk for receiving an insulin that was not effective. During an interview on 01/17 at 5:00 PM, the Interim Administrator said he expected expired medications to be pulled from the carts. The Interim Administrator said the DON was responsible of making sure there were no expired medications on the carts. The Interim Administrator said he expected the insulin to be dated when first opened. The Interim Administrator said by having expired medications on the cart could place the resident at risk for receiving an expired medication resulting in ineffective results. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Medication Storage dated 12/01/22, indicated .unused medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications, with worn, illegible or missing labels. These medications are destroyed win accordance with our Destruction of unused drugs policy . Record review of the facility's policy titled Destruction of Unused Drugs dated 07/01/22, indicated .All Unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations unused, unwanted, and non-returnable medications should be removed from their storage area and secured until destroyed . Record review of the facility's policy titled Multi-dose Vials dated 09/01/22 indicated .multi-dose vials will be relabeled with a beyond use date, 28 days after vial is opened or punctured (unless otherwise specified by the manufacturer). Follow the manufacturer's label to verify the beyond use date as some multi-dose vials expire sooner than 28 days after opening unit manager will perform random checks of opened multi-dose vials for appropriate dating.

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review the facility failed to provide or obtain laboratory services to meet the needs of 3 of 20 residents reviewed for laboratory services. (Resident # 44, Resident #35, and Resident #34) The facility failed to draw PT/INR (A prothrombin time (PT) test measures how long it takes for a clot to form in a blood sample. An INR (international normalized ratio) is a type of calculation based on PT test results) level for medication Coumadin (is a blood-thinning medicine that's used to treat and prevent dangerous blood clots) for Resident # 44 as ordered monthly for five months. 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. 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. These failures resulted in an identification of an Immediate Jeopardy (IJ) at 12:05 p.m. on 01/13/23. While the IJ was removed on 01/18/23, the facility remained out of compliance at the severity of no actual harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not having their medications at a therapeutic level, delays in treatment, and/or deterioration in condition. Findings included: 1. Review of Resident #44's electronic face sheet dated 01/13/23 revealed he was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of high blood pressure, seizures, stroke, and anemia (low blood). Review of Resident #44's quarterly MDS assessment dated [DATE] revealed under Section B, Hearing, Speech, and Vision, he was coded as 2 for sometimes understands and sometimes understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 99 for severely impaired cognition. Section G, Function Status under section B indicated he needed total assist with dressing, personal hygiene, and extensive assist with bed mobility, transfers, eating and toileting. Section N, Medication, under section N0410 indicated Resident #44 received 7 days of Coumadin during the look back period. Review of Resident #44's physicians orders dated 1/13/22 revealed PT/INR to be drawn every 30 days for diagnosis of prostatic heart value (are designed to replicate the function of native valves by maintaining unidirectional blood flow). (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #44's comprehensive person-centered care plan dated 01/13/21 when it was initiated, and it was revised on 01/14/21. Focus indicated: Resident #44 had the potential for alteration in bleeding tendencies and increased bruising related to anticoagulants therapy of Coumadin. Interventions indicated: Administer medication as ordered, monitor for side effects and report ill findings to physicians. Review of Resident #44's labs did not reveal any PT/INR labs since 07/13/22 which was ordered monthly. During an interview on 01/12/23 at 5:37 p.m., LVN C said Resident #44 was on Coumadin and should be getting monthly Coumadin levels and failure to get labs could result in bleeding. During an interview on 01/12/23 at 5:46 p.m., LVN R said when charge nurses received new lab orders, they filled out a lab requisition and placed it in the lab book. LVN R said charge nurses then placed on the 24-hour report book to follow up on labs. LVN R said Resident #44 took Coumadin and thought he had a recent lab result. LVN R called the lab company to verify the last PT/INR and they confirmed his last results were PT-31. 2 indicating high and INR-2.7 indicating high drawn on 07/13/22. LVN R said failure to do labs as ordered with Coumadin could cause Resident #44 to bleed out. During an interview on 01/12/23 at 5:50 p.m., the DON said she was aware Resident #44 did not have his Coumadin level drawn monthly as ordered. The DON said Resident #44's last coumadin level was last drawn on 07/13/22. The DON said it took time to get things in order and she was still working on this process. The DON said she did not have a system in place to monitor labs at this time During an interview on 01/12/23 at 6:10 p.m., the RNC said she was unaware Resident # 44 did not have a current PT/INR level but would make sure he got one done. The RNC said it is important to have the PT/INR drawn as ordered to ensure residents are in therapeutic levels and failure to do labs could cause bleeding. During a phone interview on 01/13/23 at 8:40 a.m., the Primary doctor said he was not aware PT/INR levels had not been drawn since 07/13/22. The Primary doctor said the facility should have drawn the PT/INR level as ordered. The Primary doctor said failure to draw PT/INR levels could lead to Resident #44 bleeding and having another stroke. Record review of Resident #44's progress note dated 01/13/2023 at 5:28 p.m., revealed PT/INR lab results received, PT 17.1, (normal range=9.0-12.2) and INR 1.4 (normal range 0.8-1.1). Physician made aware, new order to discontinue Coumadin 7.5mg and begin Coumadin 10 mg, give 1 tablet by mouth daily. Attempted to notify daughter to make aware of changes, call went unanswered. Resident #44 made aware of new change. Coumadin 10mg administered at this time, and new order to recheck PT/INR in one week. 2. Record review of a face sheet dated 01/17/23 indicated Resident #34 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of cellulitis (bacterial skin infection that causes redness, swelling, and pain to the affected area), Chronic obstructive pulmonary disease with acute exacerbation (group of lung diseases that cause airflow blockage and breathing related problems), acute systolic congestive heart failure (left ventricle of heart becomes weak), and weakness. (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 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the quarterly MDS dated [DATE] indicated Resident #34 was usually understood and understood others. The MDS revealed Resident #34 had a BIMS score of 13 indicating intact cognition. The MDS indicated Resident #34 required extensive assistance with bed mobility, toileting, and personal hygiene. Resident #34 was totally dependent on dressing and bating. The MDS under section O, special treatments, procedures, and programs, had IV medications checked indicating Resident #34 had received IV medications within the last 14 days. Record review of Resident #34's comprehensive care plan did not indicate Resident #34 was receiving IV antibiotics. Record review of the order summary report dated 01/17/23 indicated Resident #34 had an order for Vancomycin HCL intravenous solution 750-0.9mg/150mls-% Use 150ml intravenously every 12 hours for cellulitis to right hand for 10 days with an order start date of 01/16/23. Record review of the hospital patient discharge summary report dated 01/15/23 indicated new medications to start included Vancomycin HCL injection 750mg/sodium chloride 0.9% bag 250ml take IV piggyback every 12 hours. 250ml/hr. *Hold dose and DO NOT administer IF Trough is 20 or higher. Get trough level before 1st dose on 01/16/23. Record review of the lab request form dated 01/16/23 indicated Vancomycin trough to be collected on 01/18/23. During an interview on 01/17/23 at 09:45 AM, Resident #34 said he received his first dose of IV medication last night. During an interview on 01/17/23 at 09:50 AM, LVN L said Resident #34 received his first dose of Vancomycin last night and was unsure if the vancomycin trough was obtained prior to Resident #34's first dose of vancomycin. During an interview on 01/17/23 at 12:51 PM, ADON A said she did not see the order to obtain a trough level before the first dose of vancomycin for Resident #34 and it was not obtained. ADON A said by not obtaining the vancomycin trough level, Resident #34 could be at risk for receiving more than the therapeutic dose of vancomycin. During an interview on 01/17/23 at 1:57 PM, the RNC said they should have obtained a vancomycin trough level prior administering the first dose of vancomycin. The RNC said by not obtaining the trough level as ordered the resident was a risk for receiving the wrong dose of vancomycin. The RNC said the nurse who hung the medication was responsible for ensuring Resident #34 had a vancomycin trough level prior to receiving his first dose of vancomycin. During an interview on 01/17/23 at 5:00 PM, the Interim Administrator said he expected the nurses to follow the physician orders. The Interim Administrator said by not following the physicians' orders could cause the resident to have adverse effect. Record review of the facility's policy titled Diagnostic Testing Services dated 07/01/22 indicated . this facility will provide the appropriate diagnostic services (laboratory and radiology) required maintain the overall health of its residents and in accordance with state and federal guidelines . (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Record review of Resident #35's electronic face sheet, dated 01/13/23, revealed an [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. Review of Resident #35's physicians orders revealed, HGBA1C every 6 months in March and September. Review of Resident #35's comprehensive person-centered care plan dated 03/30/18 when it was initiated, and it was revised on 11/08/22. Focus indicated: Resident #35 has the potential for complications related to diagnosis of Diabetes Melilites. Intervention: HBGA1c every 6 months, administer medication as ordered by physician and monitor for side effects. During an interview on 01/12/23 at 5:46 p.m., LVN R said when charge nurses receive new lab orders, they fill out a lab requisition and place in lab book. LVN R said charge nurses then place on 24-hour report book to follow up on labs. LVN R verified order for Resident #35's HGBA1C to be drawn in March and September. LVN R said failure to do this lab as ordered could lead to Resident #35 not receiving correct dose of medication. During an interview on 1/17/23 at 2:06 p.m., the RNC said all labs should be drawn as ordered. RNC said the charge nurses are responsible to ensure orders are received and lab requisitions are filled out completely. The RNC said administrative nurses was to follow up on all labs. The RNC said without labs been drawn as ordered, doctors would not know if the residents were within a therapeutic range. During an interview on 01/17/23 at 2:25 p.m., ADON D said she expected the charge nurses to fill out the lab requisition and to make sure it was done. ADON D said she expected the charge nurses once lab received back to notify the physician because writing faxed on paper does not tell us anything. ADON D said the ADON's should be following up on labs. ADON D said Resident #44 could bleed out without propre dose of medication. ADON D said Resident #35's oral, or insulin medication could need readjustment but without proper lab they could not detect therapeutic levels and could lead to organ failure. During an interview on 01/17/23 at 6:00 p.m., ADON D said Resident # 35 did not get her HGBAIC in September as ordered. ADON D said she was unaware why Resident #35 HGBA1C was not done. ADON D said with the new lab system, hopefully no more labs will be missed. The Administrator was notified 01/13/22 at 1:20 p.m. that an Immediate Jeopardy (IJ) was identified due to the above failures. The IJ template was provided on 01/13/22 at 1:25 p.m. and a Plan of Removal (POR) was requested. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following Plan of Removal submitted by the facility was accepted on 01/15/23 at 5:00 p.m. and included the following: 1. Resident has received lab draw on 01/12/23. 2. All resident on anticoagulant identified, only one identified. Identified by report and database confirming any resident on anticoagulant. Every monthly order in DCOL lab binder. Completed 01/13/23. 3. MD notified of any residents without current PT/INR. Zero identify. Completed 1/13/23 4. Order for new PT/INR to be immediately and lab notified. Completed 01/13/23 5. Families made aware. Completed 01/13/23 6. Orders for routine lab draws for anticoagulants current and corrected. DON insured lab and orders corrected. Completed 01/13/23. 7. In-serviced all nursing staff of all residents on anticoagulants and routine lab orders. In-service completed by DON. In-service included anticoagulants and monitoring. In-service included how to run anticoagulant report from PCC. Completed 01/13/23 Monitoring: Interviews on 01/17/23 from 5:00 p.m. until 5:48 p.m., the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Interviews with 3-6am-6pm (LVN KK, LVN R and ADON G and 2-6pm-6am (LVN OO and LVN M) nurses who indicated they had received a written in-service regarding monitoring of labs. What blood thinners are such as medicines that prevent blood clots from forming. Residents who may needs blood thinners, with a certain heart or blood vessel diseases or an abnormal heart rhythm called atrial fibrillation. The different types of blood thinners which are anticoagulants, such as heparin or Coumadin, because they slow down your body's process of making clots and antiplatelets, such as aspirin and clopidogrel, which prevent blood cells called platelets from clumping together to form a clot. How to take blood thinners safely by getting labs to ensure you're taking enough medicine to prevent clots, but not so much that it causes bleeding; and the side effects of blood thinners was bleeding. All the nurses above stated they knew how to run a report to check to ensure any resident on Coumadin had an order for PT/INR. Record review of an in-service training report dated 1/13/23 indicated anticoagulants and monitoring were the topic of the in-service. The training session included: What are blood thinners? Blood thinners are medicines that prevent blood clots from forming. They do not break up clots that you already have. But they can stop those clots from getting bigger. It's important to treat blood clots, because clots in your blood vessels and heart can cause heart attacks, strokes, and blockages. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Who needs blood thinners? You may need a blood thinner if you have: Certain heart or blood vessel diseases An abnormal heart rhythm called atrial fibrillation A heart valve replacement A risk of blood clots after surgery Congenital heart defects What are the different types of blood thinners? There are different types of blood thinners: Anticoagulants, such as heparin or warfarin (also called Coumadin), slow down your body's process of making clots. Antiplatelets, such as aspirin and clopidogrel, prevent blood cells called platelets from clumping together to form a clot. Antiplatelets are mainly taken by people who have had a heart attack or stroke. How can I take blood thinners safely? When you take a blood thinner, follow the directions carefully. Blood thinners may interact with certain foods, medicines, vitamins, and alcohol. Make sure that your health care provider knows all of the medicines and supplements you are using. You may need regular blood tests to check how well your blood is clotting. It is important to make sure that you're taking enough medicine to prevent clots, but not so much that it causes bleeding. What are the side effects of blood thinners? Bleeding is the most common side effect of blood thinners. They can also cause an upset stomach, nausea, and diarrhea. Other possible side effects can depend on which type of blood thinner that you are taking. Call your provider if you have any sign of serious bleeding, such as: Menstrual bleeding that is much heavier than normal Red or brown urine Bowel movements that are red or black (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Bleeding from the gums or nose that does not stop quickly Vomit that is brown or bright red Coughing up something red Severe pain, such as a headache or stomachache Unusual bruising A cut that does not stop bleeding A serious fall or bump on the head Dizziness or weakness ANTICOAGULANT MONITORING Keywords: Oral anticoagulant therapy TYPES OF ANTICOAGULANT APPROPRIATE TESTS See also Thrombolytic therapy (Thrombolysis). The type of tests and frequency of testing depends on the anticoagulant therapy and indication, as well as clinical history. Heparin (standard, unfractionated) Prior to commencing Full blood count (including platelet count), Coagulation profile (including APTT, INR, Prothrombin time). Platelet count is recommended on day 5 post commencement of therapy. The method for monitoring continuous IV heparin infusion is usually APTT, however Activated clotting time (ACT) and Anti factor Xa are also used. The level of anticoagulation may be monitored with the APTT and/or Anti factor Xa level, however monitoring(including the test and frequency) should be according to local guidelines. Prophylactic (low dose) heparin does not usually require monitoring. In the event of bleeding on heparin, urgent APTT and Full blood count should be performed. If progression of thrombosis, or thrombosis in other site(s) while patient on heparin, causes include: Inadequate anticoagulation Heparin-induced thrombocytopenia (HIT type II) (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Antithrombin deficiency APTT, Anti factor Xa See also Heparin-induced thrombocytopenia investigation Antithrombin - ideally should be deferred until heparin has been ceased (if not performed for some reason prior to heparin therapy), since heparin will reduce the measured level. Consultation with a haematologist is recommended to guide further testing and management. See also Thrombosis - venous. Low molecular weight heparin (LMWH) and heparinoids Prior to commencing, Full blood count (including platelet count), Coagulation profile (including APTT, INR, Prothrombin time) and renal function should be performed. Platelet count is recommended on day 5 post commencement of therapy. Monitoring of (full dose) low molecular weight heparin (LMWH) therapy is not generally required, except in renal failure, extremes of body weight, pregnancy or other situations where there is an increased risk of bleeding. LMWH should be used with care and monitoring in patients with any abnormality of renal function, particularly the elderly. Monitoring is with an Anti factor Xa level, but should be done in consultation with a haematologist and according to local guidelines. Monitoring of routine LMWH prophylaxis is not cost effective, is not required to achieve clinical efficacy and is not indicated to predict risk of bleeding, which is minimal with prophylactic doses in patients with normal renal function. Oral anticoagulants Warfarin (Marevan/Coumadin) Prothrombin time, INR Increased frequency of testing may be required following change in dose, change in diet/oral intake, intercurrent illness and change in concomitant medications (including antibiotics). For information on reversal of warfarin, see guidelines below. New oral anticoagulants (NOACS) NOAC do not require monitoring when used for thromboprophylaxis or therapeutic anticoagulation. However, the anticoagulant effect should be measured if: 1. Clinically significant bleeding occurs 2. There is a change in clinical circumstances (eg, urgent surgery is required) Routine coagulation studies may (but sometimes do not) provide information about the presence of anticoagulant effect (see below). (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Specific assays for quantitation of drug levels may or may not be available depending on the drug and laboratory. Due to the short half-life of these drugs, information on the time of the last dose is important in interpreting the results. Refer to coagulation laboratory. Dabigatran The Thrombin time (TT) is the most sensitive routine coagulation assay to detect the presence of dabigatran. A normal TT excludes the presence of dabigatran, however low drug levels may significantly prolong the TT, therefore the assay cannot be used to estimate plasma levels. Some laboratories may perform a drug level assay (dilute thrombin clotting time assay). Rivaroxaban The Prothrombin time, INR (using a thromboplastin that is sensitive to rivaroxaban) is the most sensitive routine coagulation assay, however a normal PT does not exclude its presence. The APTT and PT cannot estimate the intensity of anticoagulant effect Some laboratories may provide a drug specific anti-Xa for quantitative assessement of drug plasma levels. The clinical relevance of drug plasma levels is not known, and therefore should not be used to inform drug doses. Apixaban A normal PT and APTT does not exclude significant anticoagulant effect. Drug specific anti-Xa assay may be used to estimate drug plasma levels, but this is not yet widely available. Please consult with laboratory. References: Garcia DA et al; American College of Chest Physicians. Parenteral anticoagulants: Antithrombotic Therapy and Prevention of Thrombosis. 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest 2012; 141 (2 Suppl): e24S-43S. [NAME] H et al. An update of consensus guidelines for warfarin reversal. MJA 2013; 198: 198-199. [NAME] H et al. New oral anticoagulants: a practical guide on prescription, laboratory testing and peri-procedural/bleeding management. IMJ 2014; 44: 525-536. Record review of a written in-service dated 01/15/23 indicated licensed staff had been educated on labs. The CEO and interim Administrator were informed the Immediate Jeopardy was removed on 01/18/23; however, the facility remained out of compliance at a severity level of no actual harm that is not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. 46928 Record review of the original in-service conducted with all nursing staff addressed the policy for all residents with lab orders. The in-service included lab and diagnostic test result protocol. Monitoring to be completed by DON, and ADONs. In-service completed by the DON on 01/13/2023; verified by interview of in-serviced material. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	After re-entering the facility on 2/8/23 at 9:05 a.m. additional information was gathered and included the following interviews and record reviews: Record review of the laboratory process effective 01/18/23 indicated: *Admission orders were reviewed during next the clinical meeting. *All orders were checked to ensure they were entered correctly. Any unclear orders were clarified. *Any laboratory orders were verified of placement in the EMR to ensure laboratory requisitions were completed in the laboratory requisition book. *Nursing to monitor laboratory results and review to ensure the MD was aware. Any new orders received would be implemented. *Clinical meetings will occur twice a day to ensure communication was followed and any changes were updated. *Initial requisition would indicate if a resident had recurring laboratory orders. *During the daily clinical meeting, the PCC dashboard will be utilized to monitor for lab results, MD review, and followed for any order changes. Interviews on 02/08/23 from 09:51 a.m. until 11:05 a.m., the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Interview with 3- 6am-6pm (LVN B, LVN R and LVN Y) nurses who indicated the laboratory process included: when an order for a laboratory was obtained, the order was placed in the resident's electronic medical record, the laboratory requisition was filled out, placed in the laboratory book, and was written on the 24hr report. Residents with standing laboratory orders were indicated on the lab requisition form. The three LVNs said the ADONs review the lab book daily. Interview with ADON A, ADON G, and RNC indicated they had placed a laboratory monitoring process on 1/18/23. New orders and admission orders were reviewed during the next clinical meeting. The laboratory process was: -Laboratory orders received were ensured they were entered corrected in the EMR. -The laboratory requisition was completed. -The laboratory requisition was placed in the laboratory book. The laboratory book was checked daily by the ADONs. Nursing would monitor for laboratory results, notify medical director, and implement any new orders received. If a laboratory result had not been received by 3:00 p.m., the ADON would then call the laboratory to check on the results. Record review of 6 of 6 new admissions revealed if they had orders for laboratory services the laboratory levels were obtained according to orders. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of 2 of 2 resident receiving vancomycin had their vancomycin troughs completed as ordered. Record review of 4 of 4 residents reviewed for monthly laboratory orders were on the monthly laboratory log to be obtained. Record review of Resident #34's vancomycin trough level, collected on 01/18/23, was 12.1. The medical director had reviewed and signed the laboratory results which included orders to discontinue the vancomycin due to the resident's refusal. Record review of Resident #44's PT/INR results indicated his INR was 2.8. Resident #44 was to have his INR rechecked on 02/20/23. Resident #44 was on the scheduled monthly laboratory log. The administrator was notified on 2/8/23 at 7:25 p.m. the immediacy remained in place until 1/18/23.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 33249 Based on interviews and record reviews, the facility failed to provide sufficient support personnel to carry out the functions of the food and nutrition services safely and effectively for 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure sufficient dietary staff was present for 3 of 7 days of meal service observed. This failure could place residents at risks for not receiving meals at designated mealtimes. Findings included: Record review of a dietician cleanliness report dated 11/11/2022 indicated the following: *Air conditioner vent (ceiling) needs cleaning *Plate covers stacked wet *Wipe down front of steam table *Touch up paint to walls *Outside door should be smooth and non-porous *Drip tray empty but had a grease buildup in the corners -fire hazard *Clean vent-a-hood filters *Clean wall under dish machine area *Clean garbage disposal *Clean light cover and ceiling in dish room *Pantry floor needs to be stripped and sealed *Walk in cooler lean fan cover-condensation dripping on foods. During initial tour on 01/09/2023 at 9:55 a.m., the following was observed: *Stove top with chunks of burned food and black colored buildup *Microwave oven with dried, brown colored food build up (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*4-ounce glass bowls stacked facing upward under steam table with water and black mater floating in the bowls. *Electrical outlet cover with sticky yellow colored greasy build up *Wall behind steam table with splashes of food material *Ceiling with dust like material above the dish machine *Manuel can opener with black sticky build up to the piercing blade of the can opener. *Dry food storage containers for beans, corn meal, flour, noodles covered with a sticky, and dusty film Record review of the dietary work schedule indicated: *Monday 01/09/2023 there were 2 staff scheduled for the entire day of meal services. *Tuesday 01/10/2023 there were 2 staff scheduled for the entire day of meal services. *Wednesday 01/11/2023 there were 3 staff scheduled for the entire day of meal services. Record review of the dietary work schedule dated 01/01/2023 - 01-21-2023 had 4 staff assignments including the dietary manger. During an observation and interview on 01/09/2023 at 10:15 a.m., the cook indicated she and the dietary manager were the only staff in the kitchen today. The cook said the lack of helper staff was common on most days. During an interview on 01/10/2023 at 12:30 p.m., the dietary manager said she had 3 employees for the kitchen. The dietary manger said when someone needs off or calls off there was no one to call so they will work with 2 staff. The dietary manager said the lack of staff had impacted the dietary department. The dietary manager said there was no time to deep clean the kitchen or order sufficient stocked foods for emergency use. The dietary manager said she does not have a cleaning schedule for deep cleaning . The dietary manager said she had no one applying for the any dietary positions. During an interview on 01/17/2023, the Interim Administrator said he was unaware of staffing needs of the facility at present time but he had a plan to review staffing needs.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33249 Based on observation and, interview, the facility failed to prepare puree food by methods that conserve nutritive value, flavor, and appearance for residents on a pureed diet for 1 of 5 residents reviewed for pureed diet. (Resident #57) Cook AA failed to ensure the puree diets were prepared by methods of conserving nutritive value, and flavor when she used tap water to prepare the pureed green peas. This failure could place residents on a pureed diet at risk of receiving an inadequate diet that could affect their health. Findings included: During an observation and interview on 01/09/2023 at 11:38 a.m., Cook AA used a metal measuring cup to scoop out green peas from a larger pan on the steam table. Cook AA began to puree the green peas, then walked over to the three-compartment sink faucet and obtained tap water. Cook AA then added the tap water to the green peas to achieve the texture desired. When asked why she added the tap water to the green peas she denied doing so. When asked again why she added tap water to the green peas she said, I should have used the juice off the peas for nutrition. Cook AA said she had not used the recipe for the pureed diet preparations. During an interview on 01/13/2023 at 6:00 p.m., the dietary manager said the pureed foods should be thinned with the juice from the canned vegetable or a broth. The dietary manager said the food will lose its nutrition. During an interview on 01/16/2023 at 10:45 a.m., the Administrator said she expected the pureed foods to be processed by using the juice from the foods or a broth. The Administrator said the dietary manager was responsible for ensuring foods prepared according to the recipe. A policy was requested but not provided. The policy on nutritive value of foods was requested but not provided by the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33249 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure the stove top was clean. The facility failed to ensure the microwave was clean. The facility failed to ensure the walls and ceilings were clean. The facility failed to ensure the dry storage bins were clean. The facility failed to ensure the can opener was clean. The facility failed to ensure the serving bowls were clean. The facility failed to ensure the electrical outlet was clean. Findings included: During initial tour of the kitchen on 01/09/2023 at 9:55 a.m., the following was observed: *Stove top with chunks of burned food and black colored buildup *Microwave oven with dried, brown colored food build up *4-ounce glass bowls stacked facing upward under steam table with water and black mater floating in the bowls. *Electrical outlets cover with sticky yellow colored greasy build up *Wall behind steam table with splashes of food material *Ceiling with dust like material above the dish machine *Manuel can opener with black sticky build up to the piercing blade of the can opener. *Dry food storage containers for beans, corn meal, flour, noodles covered with a sticky, and dusty film. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/10/2023 at 12:30 p.m., the dietary manager said she had 3 employees for the kitchen. The dietary manager said the lack of staff had impacted the dietary department. The dietary manager said there was not time to deep clean the kitchen or order sufficient stocked foods for emergency use. The dietary manager said she does not have a cleaning schedule for deep cleaning. During an interview on 01/16/2023 at 10:45 a.m., the Administrator indicated she was responsible for the oversight of the dietary department. The Administrator said she had not made sanitation rounds in the dietary department. Record review of a Sanitation Inspection policy dated 07/01/2022 indicated it is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary, and in compliance with applicable state and federal regulations. Policy Explanation and Compliance Guidelines: 1. All food service areas shall be kept clean, sanitary, free from litter, rubbish, and protected from rodents, roaches, flies, and other insects. 2. The department shall establish a sanitation program for food services based on applicable state and federal requirements. 3. The sanitation program will provide for inspections to be conducted of the food service areas. 6. The dietary manager shall develop and provide food service personnel with standard operation procedures for sanitation and daily.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections reviewed for 3 of 20 residents (Resident # 5, Resident #38 and Resident #272) and 6 of 6 staff reviewed for infection control. The facility failed to ensure staff were wearing N95 masks during a Covid-19 outbreak per their facility response plan (CNA Q, CNA V, CNA W). CNA P failed to wash her hands and to change her gloves during incontinent care for Resident #38. The facility failed to ensure staff were washing hands in between glove changes for Resident #5. LVN K failed to disinfect the insulin pen prior to use and the glucometer after the use with Resident #272. These failures could place residents, and staff at risk of the spread of infections, including COVID-19. Findings include: 1. Record review of a face sheet dated 01/11/23 indicated Resident #272 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of type 2 diabetes (a chronic condition that affects the way the body processes blood sugar glucose), heart failure (a chronic condition in which the heart does not pump as well as it should), and high blood pressure. Record review of the annual MDS dated [DATE], indicated Resident #272 was understood and understood others. The MDS revealed Resident #272 had a BIMS score of 14 indicating intact cognition. The MDS indicated Resident #272 required extensive assistance with bed mobility, transfers, locomotion, toileting, and bathing. Resident #272 required supervision with dressing, eating and personal hygiene. The MDS under section N, medications, indicated Resident #272 received insulin injections seven times in the last seven days. Record review of the order summary report dated 01/11/23, revealed Resident #272 had an order for Novolog Solution (insulin Aspart) inject 15 units subcutaneously (under the skin) before meals for hyperglycemia (high blood sugar) with an order date of 01/07/23. Record review of the comprehensive care plan dated 01/10/23 with a revision date of 01/11/23 indicated Resident #272 had diabetes and received insulin injections with interventions to give diabetic medications as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/10/23 at 11:36 AM, LVN K donned gloves and obtained Resident #272's fingerstick blood sugar. After removing test strip from glucometer, LVN K placed glucometer on top of the nurse's cart and proceeded to obtain Resident #272's Novolog insulin pen. LVN K took off the cap of the insulin pen and applied the needle to it. LVN K did not sanitize the tip of the insulin pen prior to applying the needle. LVN K proceeded to administer the 15 units of Novolog insulin to Resident #272. After medication administration, LVN K removed gloves and performed hand hygiene. LVN K placed the used glucometer inside the nurse's cart without disinfecting it. LVN K said he should have cleaned the tip of the insulin pen prior to applying the needle and should have disinfected the glucometer after he used it on Resident #272. LVK K said by not disinfecting the glucometer and insulin pen, the resident could be at risk for infection. During an interview on 01/17/23 at 12:51 PM, ADON A said she expected the glucometer to be cleaned before and after each use with a disinfecting wipe and allowed to dry. ADON A said she expected the tip of the insulin pen be cleaned with alcohol wipes prior to applying the needle. ADON A said by not properly disinfecting the insulin pen or glucometer the residents could be at risk for infection. During an interview on 01/17/23 at 1:57 PM, the RNC said she expected the glucometer to be cleaned before and after each use. The RNC said she expected the insulin pen to be cleaned prior to accessing it. The RNC said by not properly disinfecting the glucometer and insulin pen the residents were at risk for cross contamination and infection. During an interview on 01/17/23 at 5:00 PM, the Interim Administrator said he expected the glucometer and insulin pens to be disinfected. The Interim Administrator said by not properly cleaning the glucometer and insulin pen it placed the residents at risk for infection. Record review of the facility's policy titled Insulin Pen dated 07/01/22, indicated .remove the pen cap from the insulin pen. Wipe the rubber seal with an alcohol pad. screw the pen needle onto the insulin pen Record review of the facility's policy titled Obtaining a Fingerstick Glucose Level revised on 10/11, indicated Always ensure that the blood glucose meters intended for reuse are cleaned and disinfected between resident uses . 33249 2) Record review of a face sheet dated 01/13/23 indicated Resident #38 was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of stroke, type 2 diabetes (chronic condition that affects the way the body processes blood sugar), weakness, right sided weakness, and atrial fibrillation (irregular heartbeat). Record review of the MDS assessment dated [DATE] indicated Resident #38's MDS had not been completed. Record review of Resident #38's comprehensive care plan dated 12/02/22 and revised on 12/09/22 indicated Resident #38 had cognitive impairment due to memory problems. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/10/2022 at 11:05a.m-11:30a.m., Resident #38 had his feet off the bed and was expressing the desire to get up. CNA P donned her PPE including a pair of gloves at the door. CNA P assisted Resident #38's feet back up on the mattress. CNA P removed the linen off Resident #38. CNA P then opened Resident #38's brief. CNA P began cleaning Resident #38's peri area wiping several times with the same wipes. CNA P then asked Resident #38 to roll over. CNA P ran out of wipes, so she walked to the dresser and open the top drawer looking for more wipes, never removing her soiled gloves. CNA P then walked to the room door opened the door with the same soiled gloves on and told LVN L to bring more wipes. LVN L provided CNA P with more wipes. She touched the bag of wipes with her dirty gloves on to finish cleaning the bowel movement from Resident #38. CNA P then took the new brief and applied the brief. CNA P then removed her gloves. CNA P assisted Resident #38 to his wheelchair not using hand sanitizer or washing her hands. CNA P said she should have changed her gloves between clean and dirty, and she should have not wiped using the one wipe multiple times. LVN L said not changing your gloves, cleansing your hands, and using separate wipes could cause an infection. During an interview on 01/17/2023 at 2:39 p.m., the Regional Corporate Nurse said she expected the CNAs to have had skills check off for incontinent care. The Regional Corporate Nurse said she would expect the CNAs to change gloves between clean and dirty. The Regional Corporate Nurse said not changing your gloves, washing hands, or using sanitizer causes a risk of infection. The Regional Corporate Nurse said the DON was responsible for ensuring check offs were completed. During an interview on 01/17/2023 at 4:38 p.m., the Interim Administrator said he was not a nurse therefore he could not answer concerning the technique, but he said not completing incontinent care correctly could cause infections. Record review of a Healthcare-Associated Infections, identifying policy dated September 2017 indicated: The facility shall attempt to identify and distinguish healthcare-associated infections from those acquired in the community. Policy interpretation and Implementation 1. Healthcare-associated infections (HAIs) are those that are acquired during the delivery of healthcare across settings, in contrast to those that were acquired prior to entering the healthcare setting but may persist after admission to the facility. 2. The goals of determining healthcare-associated infections are: a. to identify and correct breaches in infection control practices that may have contributed to the spread (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of a healthcare-associated infection. b. to prevent the further spread of infection (resident-to-resident, staff-to resident) through the initiation of appropriate isolation precautions where warranted; and c. to identify, treat and report epidemiologically important organisms (e.g., C. difficile, MDROs) that have a high risk of transmission, severity of disease, and/or are difficult to treat. 45879 3. Record review of Resident #5'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 multiple sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue), sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death), anxiety (what we feel when we are worried, tense or afraid), high blood pressure, and Alzheimer's (a type of dementia that affects memory, thinking and behavior). Record review of Resident #5's quarterly MDS assessment, with an ARD of 10/26/22, revealed under Section B, Hearing, Speech, and Vision, was coded as a 0 indicating she understands and was understood by others. Section C, Cognitive Patterns, under section C0500 Brief Interview for Mental Status, which indicated a score of 14 for cognitive intact cognition. Section G, Function Status, under section B indicated she needed extensive assistance with bed mobility, personal hygiene, total assist with transfers, dressing, bathing, and supervision with eating. Section M, Skin Condition, under section M1200 she received pressure ulcer/injury care and application of nonsurgical dressing during the look back period. Review of Resident #5's comprehensive person-centered care plan dated 12/27/17 when it was initiated, and it was revised on 01/13/23. Focus indicted: Resident #5 was at risk for further skin breakdown, also has wound to right, distal, lateral calf lower leg and pressure area to right ischium related to immobility, incontinence, and disease process. Intervention indicated: Keep physician and RP informed of my progress. During an observation and interview on 01/11/23 at 11:10 a.m., ADON G was performing wound care on Resident #5, when she went from cleaning wound to left ischium to applying clean dressing without changing gloves or washing her hands. ADON G cleaned right ischium and did not wash her hands or apply clean gloves before applying clean dressing. ADON G said she should have changed her gloves and washed her hands in between dirty to clean to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/10/23 at 5:22 p.m., CNA Q was observed going in and out of resident's rooms on hall six hundred wearing a surgical mask. CNA Q said she had on a surgical mask because they did not have any N95 mask when she entered the facility. CNA Q said she had been trained and had several infection related in-services on what to wear during an outbreak. CNA Q said she knew who to ask for one, but she did not. CNA Q said failure to wear proper mask could lead to the spread of Covid. During an observation and interview on 01/13/23 at 3:57 p.m., CNA V observed assisting a resident at lunch with a surgical mask on and was currently weighing residents with a surgical mask on. CNA V said she had been in-serviced on the proper mask to wear but it was hard to breathe in them. CNA V reached over nurses' station and placed on a N95 mask. CNA V said failure to wear proper mask while providing care could cause the residents to become ill. During an observation and interview on 01/15/23 at 6:18 p.m., observed CNA W picking up residents' trays on hall two hundred wearing no mask. CNA W said she knew she was supposed to have on a mask, but they did not have any N95 mask when she entered the facility. CNA W said she was aware of where she could get a mask but started working and forgot. CNA W said failure to place on proper mask could cause residents to become ill. During an interview on 01/17/23 at 2:06 p.m., the RNC said she expected everyone to wear the mask, change gloves properly and wash hands properly while during wound care according to protocol. The RNC said administrated nurses are the overseers to make sure everyone was wearing the correct mask, doing proper glove changes, and hand washing. The RNC said failure to wear the proper mask or do good handwashing could lead to spreading diseases and infection. During an interview on 01/17/23 at 2:25 p.m., ADON A said she expected everyone to wear the proper mask, change gloves and preform hand washing properly while doing treatments. ADON A said she was the facility's Infection Preventionist and had done several Covid related in-services. ADON A said everyone could look and see if staff had on the correct mask and if not correct them. ADON A said failure to have on the proper mask or do proper handwashing could lead to the spread of infection. Record review of COVID-19 infection prevention and control measures policy dated September 2021. This facility follows infection prevention and control practices recommended by the Center for Disease Control and prevention to prevent the transmission of COVID-19 within the facility the measures include A) screening, B) distancing, C) facility wide testing, D) vaccination, E) standard precaution, F) transmission-based precautions, G) universal source control, H) appropriate use of PPE, and I) environmental cleaning and disinfecting. Outbreak Quick reference guide stated test our staff and residents regardless of vaccination status. You will continue this practice every three to seven days until you have no positive for 14 days. All staff not testing during scheduled days' time must stop at the screening station and test prior to entry into the facility. Convert all staff to N95 doing outbreak testing. Follow your specific policy and procedure for visitation but remember essential care visits are always allowed. Review refresh and educate on your COVID-19 policy and procedure and infection control (IE proper PPE usage hand washing and quarantine process).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on interview, and record review, the facility failed to ensure the resident's medical record included documentation that indicates the resident either received the influenza and the pneumococcal immunizations or did not receive the immunizations due to medical contraindications or refusals for 4 of 20 residents reviewed for immunizations. (Resident #'s 32, 60, 119, and 120) The facility failed to ensure Resident #32's medical record contained evidence of the pneumococcal immunization or declination. The facility failed to ensure Resident #60's medical record contained evidence of the influenza and the pneumococcal immunization or declination. The facility failed to ensure Resident #119's medical record contained evidence of the influenza and the pneumococcal immunization or declination. The facility failed to ensure Resident #120's medical record contained evidence of the influenza and the pneumococcal immunization or declination. These failures could place residents at risk for contracting a viral disease that could spread through the facility and cause respiratory complications, and potential adverse health outcomes. Findings included: 1)Record review of a face sheet dated 1/13/2023 indicated Resident #32 was a [AGE] year-old female who admitted on [DATE] with the diagnosis of stroke, pain, seizures, dysphagia, and malnutrition. Record review of an Annual MDS dated [DATE] indicated Resident #32 sometimes understands and was sometimes understood. Resident #32's MDS indicated she had the inability to recall. The MDS in Section O0300 indicated she was offered the pneumococcal vaccination and declined. Record review of the comprehensive care plan dated 04/08/2021 and revised on 05/03/2021 indicated Resident #32 required assistance with her ADLs including bed mobility. The interventions included to have the assistance of one to two staff for bed mobility. Record review of Resident #32's immunization report dated 01/13/2023 indicated she had not had the pneumococcal vaccination or declined the vaccination. 2) Record review of Resident #60's face sheet dated 01/13/2023 indicated he was an [AGE] year-old-male who admitted on [DATE] with the diagnoses of anemia, anxiety disorder, and Post-Traumatic Stress Disorder. Record review of Resident #60's physician's orders dated 01/13/2023 indicated he had an order for the administration of the influenza vaccine to be administered annually and the pneumonia vaccine to be administered every 5 years dated 06/21/2022. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an Immunization Report for Resident #60 indicated there were no immunizations administered or declined for influenza or pneumonia. 3) Record review of a face sheet dated 01/11/2023 indicated Resident #119 was an [AGE] year-old female who admitted on [DATE] with the diagnosis of joint replacement surgery, fracture of the right femur, and presence of an artificial right hip joint. Record review of an Immunization Report for Resident #119 indicated there were no immunizations administered or declined for influenza or pneumonia. 4) Record review of a face sheet dated 01/12/2023 indicated Resident #120 was a [AGE] year-old male who admitted on [DATE] with the diagnosis 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 an Immunization Report for Resident #120 indicated there were no immunizations administered or declined for influenza or pneumonia. Record review of the CMS-672 completed on 01/09/2023 indicated the census was 80. In section G F144 indicated 31 residents received the influenza immunization and F144 19 residents received the pneumococcal vaccine. During an interview on 01/12/2023 at 2:24 p.m., the ADON A (Infection Preventionist) said she had been informing the DON the vaccination program was not in place. ADON A said she had informed the DON this was not in line with the infection control policy. ADON A said there were no systems in place, and she had voiced her concerns to the DON. During an interview on 01/17/2023 at 2:39 p.m., the Regional Nurse Consultant said she could not answer why Resident #'s 32, 60, 119, and 120 were not provided the flu and/or the pneumonia vaccine upon admission. The Regional Nurse Consultant said this should be reviewed during the admission process and the admitting nurse was responsible. The Infection Preventionist was also responsible and the ADON would follow up to ensure the vaccinations were offered. The Regional Nurse Consultant said the residents could become ill with the flu or pneumonia virus when not vaccinated. During an interview on 01/17/2023 at 4:55 p.m., the Interim Administrator said the vaccinations should be offered upon admission. The Interim Administrator said missing the vaccinations could cause health issues. Record review of a Vaccination of Residents policy dated October 2019 indicated all residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated. 1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. 2. Provision of such education shall be documented in the resident's medical record. 3. All new residents shall be assessed for current vaccination status upon admission. 5. If vaccinations are refused, the refusal shall be documented in the resident's medical record.