STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675954	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Perryton	3101 S. Main St Perryton, TX 79070

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview, and record review, the facility failed to ensure all residents had the right to formulate an advanced directive for 3 (Resident #3, #5 and #10) of 16 residents reviewed for advanced directives. Residents #3, #5, and #10 had DNR's in their records that were missing required information including dates and signatures. These failures placed residents at risk of not having their end of life wishes honored which could result in prolonged pain and suffering and physical harms in the event of CPR being administered against a resident's wishes. Findings include: Resident #3 Record review of the face sheet dated [DATE] in the clinical record for Resident #3 revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), abnormalities of gait, muscle weakness, hypertension (a condition in which the force of the blood against the artery walls is too high), major depression(a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), congestive heart failure(a chronic condition in which the heart does not pump blood as well as it should), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), and basal cell carcinoma (cancer that begins in the lower part of the epidermis (the outer layer of the skin). Under the section Advanced Directives Resident #3 was listed as a DNR. Record review of the clinical record for Resident #3 revealed the last MDS assessment completed was a quarterly dated [DATE] with a BIMS of 10 indicating she was moderately cognitively impaired, and she required partial to moderate assistance with most of her activities. Record review of the clinical record for Resident #3 revealed a care plan with the following: Problem: (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Problem start date [DATE]. Resident request of DNR status. Goal: Residents' rights will be maintained. Record review of the clinical record for Resident #3 revealed a Clinical Physician Orders summary printed [DATE] with the following: Code Status DNR - (No active or revision date listed) Record review of the clinical record for Resident #3 revealed a DNR dated [DATE] (by Resident #3) with the following: -Section-Physician Statement-there was no printed physician name, no date for the physician's signature, and no printed license number for the physician. -There was no second signature for Resident #3 in the All person who have signed above must sign below, acknowledging that this document has been properly completed section. Resident #5 Record review of the face sheet dated [DATE] in the clinical record for Resident #5 revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include multiple Sclerosis(potentially disabling disease of the brain and spinal cord (central nervous system), borderline personality disorder (a personality disorder characterized by severe mood swings, impulsive behavior, and difficulty forming stable personal relationships), muscle weakness, bipolar disorder(disorder associated with episodes of mood swings ranging from depressive lows to manic highs), suicidal ideation, hypertension(a condition in which the force of the blood against the artery walls is too high), and seizures(sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain). Under the section Advanced Directives Resident #5 was listed as a DNR. Record review of the clinical record for Resident #5 revealed the last MDS assessment completed was an annual dated [DATE] with a BIMS 0f 14 indicating she was cognitively intact, and she required partial to moderate assistance with most of her activities. Record review of the clinical record for Resident #5 revealed a care plan with the following: Problem: Resident has requested a DNR status. Date initiated: [DATE]. Interventions: Respect residents' rights to make end of life decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the clinical record for Resident #5 revealed a Clinical Physician Orders summary printed [DATE] with the following: Code Status DNR - Revision date [DATE] Record review of the clinical record for Resident #5 revealed a DNR dated [DATE] (by the physician) with the following: -Section A. Declaration of the adult person. -there is no date for the resident's signature and no printed name for the resident. -Section All persons who have signed above must sing below, acknowledging that this document has been properly completed. -there is no second signature for the resident and no second signature for Witness #1 Resident #10 Record review of the face sheet dated [DATE] in the clinical record for Resident #10 revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include type 2 diabetes(a chronic condition that affects the way the body processes blood sugar (glucose), acquired absence of right leg, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), chronic pain, major depression(a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), coronary artery disease(damage or disease in the hearts major blood vessels), and hypertension (a condition in which the force of the blood against the artery walls is too high). Under the section Advanced Directives Resident #10 was listed as a DNR. Record review of the clinical record for Resident #10 revealed the last MDS assessment completed was an annual dated [DATE] with a BIMS 0f 15 indicating he was cognitively intact, and he was independent with most of his activities. Record review of the clinical record for Resident #10 revealed a care plan with the following: Problem: Problem start date [DATE]. Resident is a DNR. Goal: Residents' wishes will be followed. Record review of the clinical record for Resident #10 revealed a Clinical Physician Orders summary printed [DATE] with the following: Code Status DNR - Revision date [DATE] (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the clinical record for Resident #10 revealed a DNR dated [DATE] (by Resident #10) with the following: -Section All person who have signed above must sign below, acknowledging that this document has been properly completed - Witness #1 signed in the physician's signature section and the physician's signature (that is in the Witness #1 section) in this section does not match the Physicians Statement section signature. During an interview on [DATE] at 08:54 AM the DON reported that when a resident is admitted she or the administrator will interview the resident to determine the resident's wishes for their code status and complete the proper paperwork to include the DNR form. The DON stated that she is the primary person responsible for ensuring that the DNR was completed. The DON reported the DNR status was reviewed with each resident's quarterly assessment. The DON reported that to determine a resident's code status staff are to check the residents printed chart at the nurse's station, that when they completely switch to electronic charting then staff can check the computer, or they have a list printed at the nurse's station that has each resident's code status. The DON reported that once the residents code status was determined the staff member was to address the resident according to the code status. If the resident was a full code, then implement CPR and if the resident was a DNR then hold CPR and notify the physician and family. The DON reviewed Resident #5's DNR and noted the missing resident information, the incorrect Physician's information, and the missing secondary signatures at the bottom of the form. The DON reviewed Resident #3's DNR form and noted the missing Physician information. The DON reviewed Resident #10's DNR form and noted the confusing physician second signature and signatures in the incorrect places. The DON reported that all three DNR's were currently invalid and therefore if any of the three residents coded (were determined to be without a heartbeat or to be breathing), they would currently be treated as a full code and CPR would be initiated. The DON reported that this would affect the residents care due to their wishes would not be followed. During an interview on [DATE] at 09:12 AM LVN A (the nurse responsible for all the residents this shift) reported that if a resident were to code, she would check the resident's chart and then handle the code according to what the chart indicated. If the resident was a full code, she would start CPR and if the resident was a DNR then she would not start CPR. LVN A reviewed Resident #3, #5, and #10's DNR's, verified the missing information, and reported that all three DNR's were currently invalid. When questioned if she would honor each of the three residents DNR's currently if she found any of the residents not breathing and without a heartbeat LVN A stated, Probably not since the DNR is not right. LVN A reported that it might affect resident care since she would have to code the resident and start CPR against their wishes and that would not be following the residents wishes. Record review of facility provided policy titled Advanced Directives, revised [DATE], revealed the following: The resident has the right to formulate to an advanced directive .Advanced directives are honored in accordance with state law and facility policy. 4. Written information includes .polices to implement advanced directives and applicable state law. Record review of OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, undated revealed the following: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview and record review, the facility failed to ensure an assessment accurately reflected a resident's status for 1 of 12 residents (Resident #7) reviewed for accuracy of MDS assessments. -The facility did not correctly identify tobacco use for Resident #7 on his annual MDS assessment. This failure to ensure accurate assessments could affect residents by placing them at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Finding include: Record review of Resident #7's face sheet, dated 3-4-2024, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia, (a group of thinking and social symptoms that interferes with daily functioning), major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), hypertension (a condition in which the force of the blood against the artery walls is too high), disorder of the brain (any condition marked by disruption of the normal functioning of the brain), muscle weakness, contact with and exposure to environmental tobacco smoke acute and chronic, family history of epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and family history of ischemic heart disease (heart weakening caused by reduced blood flow to the heart). Record review of Resident #7's annual MDS, dated [DATE], revealed that the resident had a BIMS of 15 indicating he was cognitively intact, and he had a functionality of requiring set up assistance with most of his activity except dressing, toilet use, and personal hygiene which he required two-person physical assistance. Section J-Health Conditions: J1300 Current Tobacco Use-Resident #7 was marked 0 for no use of tobacco. Record review of Resident #7's current comprehensive care plan revealed the following: Problem Start Date: 7-08-2022. Resident #7 is a risk of injury d/t smoking, delay response, d/t intellectual deficit. Record Review of Resident #7's Interdisciplinary Care Plan dated 6-14-2023 revealed the following: Activities: talks on phone, smokes Smoker-Yes Eval Done/Safety-Yes (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03-06-2024 at 08:44 AM the DON reported that Resident #7 has smoked daily for as long as she has known him which has been 7-8 years. The DON verified that she is currently responsible for completing the MDS assessments due to the low census. The DON reviewed Resident #7's last annual MDS, noted that he was not marked for tobacco use, and verified that the MDS had been marked correctly. The DON reported that she did not complete that MDS and that the person responsible no longer worked for the facility. The DON reported that if the facility was audited then the MDS would not be correct, and the facility could lose funding which would affect resident care. The DON reported that she did not feel this would affect Resident #7's care directly because he was still able to smoke and use his tobacco. The DON reported that they follow the RAI (Resident Assessment Instrument) manual for facility policy when addressing the use of the MDS. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1. 18.11 dated October 2023 revealed the following: Section J: Health Conditions- J1300: Current Tobacco Use Item Rationale Health-related Quality of Life o The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life. Planning for Care o This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation. o If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed. Steps for Assessment 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. DEFINITION (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TOBACCO USE Includes tobacco used in any form.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48208 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan, consistent with the resident rights set forth with goals for admission and desired outcomes for 1 of 16 residents (Resident #5) reviewed for care plans. Resident #5 care plan focus areas of DNR, diagnoses of hypertension, physical mobility, cognitive functioning, antidepressant medication, and psychotropic medication had minimal or no person centered goals or interventions to meet the resident's specific needs. This failure can result in inadequate/incorrect care or harm. Findings include: Record review of Resident #5's face sheet, dated 3/5/24, revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included but are not limited to multiple sclerosis (disease that affects central nervous system), borderline personality disorder (a mental disorder characterized by the instability in mood, behavior, and functioning), need for assistance with personal care, and muscle weakness. Record review of Resident #5's annual MDS assessment, dated 1/12/24, revealed Resident #5 has a BIMS of 14 indicating Resident #5 is cognitively intact. Resident #5's functional abilities indicated Resident #5 needed supervision or touching assistance with eating and oral hygiene, partial/moderate assistance with toileting hygiene, upper body dressing, personal hygiene, and rolling left to right, and substantial/maximal assistance with shower/bathe self, lower body dressing, putting on/taking off footwear, sit to lying, lying to sitting on side of the bed, chair/bed-to-chair transfer, and toilet transfer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's care plan, dated 1/24/24, reflected the following: Resident #5 has requested a DNR status had no goals listed to achieve resident's decision for a DNR. Problem listed as Resident #5 has dx of hypertension with a goal of Resident blood pressure will be within normal limits. There were no interventions to help achieve this goal. Problem was listed as impaired physical mobility had no goals listed and interventions of observing resident's posture and gait and observe ROM in all joints. Problem was listed as the resident has impaired cognitive function or impaired through processes with no goals or interventions listed . Problem was listed as the resident uses antidepressant medication (specify medications) r/t, with no goals or interventions. Problem listed as the resident uses psychotropic medications Abilify, Goal- the resident will be/remain free of psychotropic drug related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date and the resident will reduce the use of psychotropic medication through the review date with no interventions to achieve goal listed. Problem was listed as the resident has depression r/t, goal listed as the resident will exhibit indicators of depression, anxiety or sad mood less than daily by review date and the resident will remain free of s/sx of distress, symptoms of depression, anxiety or sad mood by/through review date with no interventions listed to achieve the goal;. Problem listed as the resident has bladder incontinence with a goal of the resident will decrease frequency of urinary incontinence from (SPECIFY) to (SPECIFY) times per week through the next review date, no interventions listed and no amount provided to observations of urinary incontinence. In an interview on 3/6/24 at 9:14 AM, DON stated she oversaw the care plans. DON stated care areas for care plans were obtained from the MDS. DON observed Resident #5's care plan and verified missing information from problems of impaired cognitive function, psychotropic medication, resident has depression, and resident has bladder incontinence. DON stated interventions were important because the staff need to know how to care for the resident and it is missing a step of the equation to meet the goal. DON stated a negative outcome could be a lot of things; resident could have an allergy to something and could cause harm to the resident. Record review of policy titled Care Plans, Comprehensive Person-Centered, revised March 2022, stated a comprehensive person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Line 3 stated the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Line 7 stated the comprehensive, person-centered care plan: a- includes measurable objectives and time frames, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c- includes the resident's stated goal upon admission and desired outcomes; d- builds on the resident's strengths; e- reflects currently recognized standards of practice for problem areas and conditions. Line 10 stated care plan interventions are chosen only after data gathering, proper sequencing of events, careful considerations of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview and record review the facility failed to develop a comprehensive care plan within 7 days after completion of a comprehensive assessment for 1 (Resident #15) of 12 residents reviewed for comprehensive care plans. The facility failed to develop Resident #15's comprehensive care plan within 7 days after completing her admission MDS assessment. The deficient practice could affect residents by delaying treatment, care, and services that could result in residents not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings include: Record review of Resident #15's face sheet dated 3-4-2024 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include fracture of other parts of the pelvis, malnutrition (lack of proper nutrition), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), chronic kidney failure (longstanding disease of the kidneys leading to kidney failure), repeated falls, pain, hypertension (a condition in which the force of the blood against the artery walls is too high), heart failure (a chronic condition in which the heart does not pump blood as well as it should), and old myocardial infarction (heart attack). Record review of Resident #15's admission MDS, dated [DATE] (Completed by the DON on 2-19-2024) revealed that the resident had a BIMS of 15 indicating she was cognitively intact, and she had a functionality of requiring the use of a walker or wheelchair and partial to moderate assistance with most activities of daily living. Record review of Resident #15's comprehensive care plan printed 3-5-2024 revealed the following: No Data Found. During an observation and interview on 03-04-2024 at 11:01 AM Resident #15 was observed in her room sleeping and did not wake to knocking or introduction. Resident #15 was noted to have a catheter bag hanging from the foot of her bed in a privacy bag and she had bilateral 1/3 bedrails up and locked in place. During an observation and interview on 03-04-2024 at 12:18 PM Resident #15 was observed in the dining room sitting in a wheelchair at a table with another resident. Resident #15's catheter was in a privacy bag, and she was overheard visiting with a staff member about her meal preferences. Resident #15 reported no issues with the facility or staff and immediately returned to conversing with the other resident at the table. Resident #15 did not acknowledge this surveyor's presence any further and did not address any further questions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03-06-2024 at 08:49 AM the DON verified that she was currently responsible for completing the MDS assessments and the care plans to include the comprehensive care plans due to the low census. the DON reported that the only care plan they currently had for Resident #15 was the base line care plan and that it was her understanding that she had 14 days after the completion of the MDS to complete the comprehensive care plan. The DON reported that if there was a different time frame requirement for the comprehensive care plan to be completed, she was not aware of it. The DON reported that if the comprehensive care plan was not completed as is should then resident care can be affected, that staff should be aware of the care listed on the comprehensive care plan. Review of facility presented policy titled Care Plans, Comprehensive Person-Centered, revised 3-2022, revealed the following: Policy Interpretation and Implementation 2. The comprehensive, person-centered care plan is developed within seven (7) days a=of the completion of the required MDS assessment (Admission, Annual, or Significant Change in Status) .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48208 Based on observation, record reviews, and interviews, the facility failed to ensure that residents unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 16 residents (Resident #5) reviewed for choices. Resident #5 was told no when asking staff to shave her legs during her showers. This failure can result in residents not receiving proper care and not attaining their highest level of physical, mental, and psychosocial well-being. Findings Include: Record review of Resident #5's face sheet, dated 3/5/24, revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included but are not limited to multiple sclerosis (disease that affects central nervous system), borderline personality disorder (a mental disorder characterized by the instability in mood, behavior, and functioning), need for assistance with personal care, and muscle weakness. Record review of annual MDS assessment, dated 1/12/24, revealed Resident #5 has a BIMS of 14 indicating Resident #5 is cognitively intact. Resident #5's functional abilities indicated Resident #5 needed supervision or touching assistance with eating and oral hygiene, partial/moderate assistance with toileting hygiene, upper body dressing, personal hygiene, and rolling left to right, and substantial/maximal assistance with shower/bathe self, lower body dressing, putting on/taking off footwear, sit to lying, lying to sitting on side of the bed, chair/bed-to-chair transfer, and toilet transfer. Record review of Resident #5's care plan, dated 1/24/24, showed a problem of Self-Care deficit: Bathing, Dressing, Feeding, with a goal of resident would participate in self-care activities, and interventions of encouraging resident to participate in planning day to day care, evaluate resident's ability to perform ADLs, maintain consistent schedule with daily routine, provide assistance with ADLs as needed. In an observation and interview on 3/4/24 at 1:21 PM, Resident #5 and FM were in resident's room. FM was sitting on the bed, shaving Resident #5's legs while resident was sitting in her wheelchair. FM stated the staff had been asked multiple times to shave Resident #5's legs and they had received different excuses such as staff did not have time, staff was too busy, or staff did not shave residents. In an interview on 3/6/24 at 9:53 AM, CNA A stated she was responsible for showers during her shift. CNA A stated she has shaven legs. CNA A stated she has told Resident #5 she was unable to shave her legs during a shower because of a heavy workload that day. CNA A stated other CNA's have told her no and verified Resident #5 has been told no before. CNA A stated a negative outcome could be mental decline. (continued on next page)

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	675954	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare of Perryton	3101 S. Main St Perryton, TX 79070

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/6/24 at 10:01 AM, DON stated CNAs were responsible for showering residents. DON stated residents were encouraged to be as independent as possible and a lot of residents needed lower body help. DON stated CNAs did shave residents when asked and they had a conversation with CNAs recently. DON stated a negative outcome could be the resident feeling disrespected, belittled, and emotional decline. In a policy titled Resident Self-Determination and Participation, revised August 2022, policy statement stated, Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life, Line 1: Each resident is allowed to choose activities, and schedule health care and healthcare providers, that are consistent with his or her interests, values, assessments and plans of care, including: Line b- personal care needs such as bathing methods, grooming styles and dress. In a policy titled Resident Rights, revised February 2021, stated employees shall treat all residents with kindness, respect, and dignity.

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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 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** 48208 Based on observations, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible and each resident receives adequate supervision for 3 of 16 residents (Resident #7, Resident #9 and Resident #10) reviewed for accidents and hazards. Smoking materials were left out unsupervised. Residents #7, #9, and #10 were smoking outside without supervision. This failure could result in physical and mental harm. Findings Include: Record review of Resident #7's face sheet, dated 3/4/24, showed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7's diagnoses include but were not limited to legal blindness (complete loss of all visual light perception), dementia in other diseases classified elsewhere, moderate (group of symptoms that affect memory, thinking, and behavior), anxiety (a physiological and psychological response that occurs when the mind and body encounter stressful, dangerous, or unfamiliar situations), disorder of brain, unspecified (conditions that affect the structure or function of the brain, causing problems with thinking, memory, movement, or emotions), and unspecified hearing loss (partial or total inability to hear). Record review of Resident #7's annual MDS assessment, dated 6/13/23, reflected resident had a BIMS of 15, indicating resident is cognitively intact. Section J reflected resident was not a current tobacco user. Record review of Resident #7's care plan, dated 6/14/23, reflected a goal of, Resident #7 is at risk of injury due to smoking, delay response r/t intellectual disabilities. Record review of Resident #7's smoking assessment, dated 2/26/24, indicated resident smoking and safety: supervision, designated smoking location, and smoking times are determined by facility policy; this evaluation will be utilized for the Resident's smoking care plan on admission as indicated. Resident #7 displayed poor vision or blindness, balance problems while sitting or standing, drops ashes on self , and follows the facility's policy on location and time of smoking. Record review of Resident #9's face sheet, dated 3/4/24, indicated a [AGE] year-old female admitted to the facility on [DATE]. Resident #9's diagnoses included but were not limited to chronic obstructive pulmonary disease with acute exacerbation (chronic inflammatory lung disease that causes obstructed airflow from the lungs), acute respiratory failure with hypoxia (lungs cannot provide enough oxygen to the body or remove enough carbon dioxide), unspecified macular degeneration (eye disease that affects central vision), and acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (a group of signs and symptoms, caused by an impairment of the heart's blood pumping function). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's annual MDS assessment, dated 9/11/23, reflected a BIMS of 15 indicating Resident #9 is cognitively intact. Section J of the MDS reflected resident is a current tobacco user. Record review of Resident #9's care plan with admitted [DATE] revealed the following: Problem: Resident #9 is a risk of injury r/t smoking. Date initiated 1-24-2024. Interventions: -Encourage her to keep lighter and cigarettes at nurses' station, although resident might refuse. -Encourage Resident #9 to follow nursing facility smoking policy when refusing to comply. Record review of Resident #9's smoking assessment, dated 1/9/24 , reflected: Line 1- supervision, designated smoking location, and smoking times are determined by facility policy; this evaluation will be utilized for the Resident's smoking care plan on admission as indicated. Resident #9 displayed poor vision or blindness and follows the facility's policy on location and time of smoking. Record review of Resident #10's face sheet, dated 3/4/24, reflected a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses include but were not limited to type 2 diabetes mellitus, chronic obstructive pulmonary disease with acute exacerbation, other lack of coordination, and tobacco use. Record review of Resident #10's annual MDS assessment, dated 11/17/24 , reflected a BIMS of 15 indicating cognitively intact. Section J reflected Resident #10 is a current tobacco user. Record review of Resident #10's smoking assessment, dated 2/7/24, reflected: Line 1 - supervision, designated smoking location, and smoking times are determined by facility policy; this evaluation will be utilized for the Resident's smoking care plan on admission as indicated. Smoking assessment indicated that resident displays balance problems while sitting or standing and follows the facility's policy on location and time of smoking. Record Review of Resident #10's care plan with last review date of 9-22-2023 revealed the following: Problem: Resident #10 is at risk for injury r/t smoking. Approach: -Resident #10 with abide by the smoking policy. -Resident #10 will keep lighter and cigarettes at nurse station. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 3/5/24 at 7:28 AM, Resident #9 re-entered the facility from the smoking area independently. In an observation on 3/5/24 at 11:01 AM, Resident #7 and Resident #9 went to the smoking area to smoke unsupervised. In an observation on 3/5/24 at 11:09 AM, a white lighter was identified on the nurse's station with no supervision. In an observation on 3/5/24 at 11:48 AM, a white lighter remained on the corner of the nurse's station. In an observation on 3/5/24 at 12:17 PM, a white lighter remained on the corner of the nurse's station. In an observation on 3/5/24 at 12:49 PM, the white lighter had been removed from the nurse's station. In an observation on 3/5/24 at 3:02 PM, Residents #7, #9, and #10 were outside smoking unsupervised. In an interview on 3/6/24 at 9:20 AM, DON observed Resident #7, #9, and #10's smoking assessments. DON verified all assessments stated residents required supervision. DON stated supervision meant someone is with the residents while residents were outside smoking. DON verified smoking materials, including cigarettes and lighters, were locked up where residents do not have access to them. DON indicated a negative outcome is residents could burn themselves or start a fire if not supervised while smoking. DON stated a negative outcome of not locking up smoking materials could be ingestion of smoking materials as residents with Alzheimer's or Dementia could grab them. Record review of policy Smoking Policy-Residents, revised August 2022, stated (line 11) any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor, or volunteer worker at all times while smoking. (Line 12) Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48208 Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen observed. Dry goods were not stored in sealed containers. Refrigerated and frozen food were not labeled or stored correctly. This failure can result in cross contamination, bacteria, pests, and harm to residents. Findings include: In an observation on 3/4/24 at 10:27 AM of the pantry: 12 oz box Signature Select Crispy Rice cereal was opened and in original box with resident's name on the top. 12 oz box General Mills Corn Chex Cereal was opened and in the original box. 28 oz Quaker Creamy Wheat was opened and in the original box. [NAME] Cake Mix was opened, in gallon sealed bag with no date Refrigerator 2 22 oz. Budding oven roasted turkey with no date Package of 7 flour corn tortillas was not dated or labeled. Gallon bag with cooked meat, not labeled or dated. 5 lb. de Pasado cheese in cardboard box and not in sealed container. Silver serving pan with tin foil on top was not labeled and not dated. Freezer Gallon bag of frozen rolls was not labeled. Gallon bag of frozen chocolate chip cookies with no label and date on container was faded. Gallon bag of breaded chicken tenders, open to air and not labeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/4/24 at 10:43 AM, DM stated an open container is not correct and that it is supposed to be sealed. DM stated a negative outcome is the food is open to getting bacteria or freezer burn. Record review of policy titled Food Receiving and Storage, revised November 2022, under heading Dry Food Storage, line 3- dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. Record review of policy titled Food Storage, dated 2013, under heading procedure- line 4 plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled. Line 12- leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Line 14- Refrigerated Food Storage- item f- all foods should be covered, labeled and dated. Line 15- Frozen Foods- item c- all foods should be covered, labeled and dated.