STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676007	A. Building B. Wing	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Rehab & Nursing	1901 Whippoorwill 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 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** 45810 Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 1 resident (Resident #70) reviewed for resident rights. The facility failed to ensure CNA D treated Resident #70 with respect and dignity when CNA D told her What ya'll need?, What, Are you going to stay up until we get off of work?, and I don't know if we going to do all that. The facility failed to ensure CNA E treated Resident #70 with respect and dignity when CNA E told her From here on out, if you want to get up, you are going to have to get up earlier than this. This ain't going to cut it. It is too close to supper. These failures could place residents at risk for diminished quality of life, loss of dignity, and self-worth. Findings included: Record review of Resident #70's face sheet dated 12/12/23 indicated she was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of Parkinson's disease (a chronic degenerative disorder of the central nervous system), diabetes (a disease that causes elevated blood sugars), depression, anxiety (an intense, excessive, and persistent worry and fear about everyday situations), and high blood pressure. Record review of Resident #70's significant change MDS assessment, dated 11/03/23, indicated she had a BIMS score of 12, which indicated moderate cognitive impairment. She was able to make herself understood and understood others. She required extensive assistance with bed mobility, transfers, dressing, toileting, and required setup for eating. The MDS indicated she had a condition or chronic disease that may result in a life expectancy of less than 6 months. Record review of Resident #70's care plan last revised on 10/06/23 indicated that she had an ADL self-care deficit with a goal for resident to maintain a sense of dignity, and interventions that included maximum assist from staff with bed mobility, transfers, toileting, dressing, and personal hygiene. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/23 at 01:52 PM Resident #70 said CNA D and CNA E yell at her and they told her and her roommate that they needed to get Jesus in their life. She said she was tired of the staff treating ugly. Resident #70 said CNA E worked well without CNA D. She said she was not afraid of them harming her, but they just talk rough and hateful to her. During an interview on 11/11/23 at 11:09 AM Resident #70's responsible party said she had talked to ADON H, and she was upset about how CNA D and CNA E talked to her. Resident #70's responsible party said her was not afraid of the staff. She said she just did not feel Resident #70 had to put up with the staff's attitudes when she asked for assistance with care. During an interview and record review on 12/11/23 at 11:46 AM, 2 separate videos were provided to this surveyor by Resident #70's responsible party. The first video was timestamped 12/06/23 at 4:34 PM, and contained 2 staff members, identified as CNA D and CNA E. The video was taken from a camera that resides in Resident #70's room. In the video CNA D and CNA E were providing care to Resident #70. CNA E told Resident #70 From here on out, if you want to get up, you are going to have to get up earlier than this. This ain't going to cut it. It is too close to supper. The second video was timestamped as 12/12/06/23 at 3:14 PM, and contained a staff member identified as CNA D. The video was also taken from the camera that resides in Resident #70's room. In the video CNA D walked into Resident #70's room and asked What ya'll need? Resident #70 asked CNA D to be transferred out of bed to her chair. CNA yelled What and asked Resident #70 are you going to stay up until we get off of work? Resident #70 answered yeah, and CNA D said I don't know if we going to do all that. During an interview on 12/11/23 at 08:43 , Resident #70 started to cry and complained that the CNA D and CNA E combination were working the 6:00 AM to 2:00 PM shift on 12/11/23 on her floor, and they had already been overheard saying they had to provide care to Resident #70 in a tone as though they did not want to provide her care. During an interview on 12/12/23 at 12:23 PM CNA E said that she was not aware of any complaints from residents about staff being rude or not respecting their dignity. She said she got along with all the residents. She said with dignity she knew she had to respect residents, knock on the door, tell them what you are doing with them, and keep them covered. CNA E said not doing those things could make residents feel bad. During an interview on 12/12/23 at 12:55 PM CNA D said she treated all residents with respect and dignity. She said she provided the care they needed and provided privacy when completing care. CNA D said she did not have any concerns with any of the residents related to dignity, resident rights, or privacy. She said if the staff did not provide respect or dignity resident could become upset. During an interview on 12/12/23 at 1:05 PM the ADON said she expected the CNAs to be respectful to all residents and treat them with dignity and respect. She said it was everyone's responsibility to ensure the residents were being treated with dignity and respect. The ADON said the failure could have caused Resident #70 emotional issues or loss of dignity. During an interview on 12/12/23 at 1:10 PM the DON said she expected the staff to respect all residents and provide dignity while caring for them. She said the failure could have caused Resident # 70 a decreased quality of life or loss of dignity. (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 12/12/23 at 01:18 PM the Administrator said his expectation was that the facility was the resident home, and all residents should be talked to with dignity and respect. He said the Administrator, himself, was overall responsible for ensuring the staff were providing care for the residents with dignity and respect, but the ADONS and DON were responsible for overseeing the staff as well. The Administrator identified the staff in the videos presented as CNA D and CNA E and said he would be completing a self-report and doing more investigation because the way the staffed talked was unacceptable. He said he had already written the CNAs up. The Administrator said the failure could have caused psychological effects and decreased quality of life. Record review of the facility Promoting /Maintaining Dignity policy dated 2/17/2017 last reviewed on 2/16/2020 indicated: Policy It is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. Fundamental Information What ifs dignity? . an innate quality of being human; a person's self-esteem. Long term care residents have dignity . they need and deserve our respect . Process 1. All staff members are involved in providing care to residents to promote and maintain resident dignity .10. Speak respectfully to residents; avoid discussions about residents that may be overheard .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on interview and record review the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change of condition for 1 of 4 Residents (Resident #35) reviewed for PASSAR (Preadmission Screening and Resident Review Services) in that: Resident #35 did not have a PASSR level II evaluation with diagnosis of PTSD (post-traumatic stress disorder). The Social Worker failed to refer Resident #35 for a resident review after being diagnosed with PTSD on 2/23/2021 until after surveyor entrance on 12/10/23. These failures could place residents at risk of not receiving the needed PASRR services to meet their individual needs and could result in a decrease quality of life. The findings were: Record review of an Admission Record dated 12/11/2023 for Resident #35 indicated she admitted to the facility on [DATE] with the most recent admission on 4/21/2022 and was [AGE] years old with diagnoses of anxiety disorder on 9/23/2019, PTSD (post-traumatic stress disorder) on 2/23/2021, and major depressive disorder (persistent feeling of sadness or loss of interest) on 4/25/2019. Record review of a PL1 (PASRR Level 1 Screening) dated 4/5/2019 for Resident #35 indicated she was negative for mental illness, intellectual disability, and developmental disability. Record review of a PL1 (PASRR Level 1 Screening) dated 12/10/2023 for Resident #35 indicated she was positive for mental illness. Record review of the facility's completed form 1012 dated 12/10/23 for Resident #35 indicated had a new diagnosis of PTSD (post-traumatic stress disorder). Record review of a Quarterly MDS assessment dated [DATE] for Resident #35 indicated she was cognitively intact with a BIMS score of 15. She had psychiatric/mood disorders of depression, anxiety, and post-traumatic stress disorder (PTSD). A referral to the local contact agency was not needed. Record review of a care plan for Resident #35 dated 9/10/2019 indicated she had depression/anxiety and used antidepressant and antianxiety medications. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/23 at 11:42 AM the Social Worker said that Resident #35 had a diagnosis of PTSD and was made aware of it about a week ago. She said Resident #35 was on psychiatric counseling services already since 2019. She said that she had just sent the new PL1 for the LIDDA. She said she has been here for about a year but was not used to doing PASRR, and the form 1012 was new to her. She said since Resident #35 was already receiving psych services it didn't occur to her to check anything else. The Social Worker said that she was notified in the morning meeting of any new diagnosis on residents and was typically made aware of psychiatric diagnosis on admission. During an interview on 12/12/23 at 12:22 PM the Administrator said the Social Worker was responsible for submitting PASRR's and her oversees her. He said they look at all new resident admissions from the previous day and it shows on the computer screen if the PASRR has been entered or not. He said that he was having issues with the Social Worker getting PASRR's submitted timely and accurately. He said his expectation was that when a resident admits the PASRR is entered into the system. The Administrator said all new diagnosis that could cause a resident to become positive are discussed in the morning meeting daily. Record review of the facility policy titled Preadmission and Screening Resident Review (PASRR) Rules The social worker/designee enters the positive PL1 into the SimpleLTC Portal for expedited Admission and Exempted Hospital Discharges.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 1 of 4 residents (Resident #18) reviewed for PASRR Level I screenings. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #18. The PASRR 1 Level screening did not indicate a diagnosis of mental illness, although the diagnosis was present upon admission. This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #18's face sheet, dated 12/12/23, indicated he was a [AGE] year-old male, admitted to the facility 02/28/23. His diagnoses included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), with an onset date of 04/04/22. Record review of Resident #18's quarterly MDS assessment, dated 09/22/23, indicated he had a BIMS score of 12, which indicated moderate cognitive impairment. The MDS further indicated he received an antidepressant medication 7 of 7 days of the assessment window. Record review of Resident #18 PASRR Level 1 Screening, printed on 12/12/23, indicated that in Section C Mental Illness was marked as no, which indicated Resident #18 did not have a mental illness. During an interview on 12/12/23 at 10:53 AM, the Social Worker said she reviewed Resident #18's diagnosis list and said he should have a positive PL1. She said it was possible that he could have had PASRR services since his admission if he was approved for PASRR services. She said she would resubmit the PL1 and let the LIDDA determine if he was PASRR positive. During an interview on 12/12/23 at 11:15 AM, the interim DON said the PL1 form should have mental illness marked yes. She said if the PL1 was filled out correctly then he may have been PASRR positive if decided by the LIDDA and could have received services since his admission. She said the SW and MDS nurse look over the PASRR forms. She said they discuss the forms in the morning meetings as well. During an interview on 12/12/23 at 11:21 AM, the Administrator said he expected the PL1 to be marked yes for mental illness so that Resident #18 could be considered for PASRR services. He said it was possible if considered positive by the LIDDA that Resident #18 could have received services since his admission. Record review of the facility's policy, Preadmission and Screening Resident Review (PASRR) Rules, last revised August 2023, stated: .It is the intent of Advanced Health Care Solutions to meet and abide by all state and federal regulations that pertain to resident preadmission and screening resident review (PASRR) rules . (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Referring Entity completes a PL1 . .if negative: .If the resident has a qualifying MI (mental illness) diagnosis and the NF feels the resident should be positive they should talk to the referring entity and ask them to correct the PL1 .

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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** 45643 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 21 residents reviewed for ADLs (Residents # 8) The facility did not trim Resident # 8's fingernails. This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health. The findings include: Record review of Resident #8's Admission Record indicated he was an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: Lack of coordination (Ataxia describes poor muscle control that causes clumsy voluntary movements), Need for assistance with personal care, Atrial Fibrillation (an irregular and often very rapid heart rhythm.) Record review of Resident #8's Quarterly MDS dated [DATE] revealed a BIMS with a score of 9, which indicated resident #8 has moderately impaired cognition. The MDS also revealed, Resident #8, required limited assistance with personal hygiene. Resident # 8 required one-person physical assistance with personal hygiene, including nail care. MDS revealed that resident # 8 did not refuse care. Record review of Resident #8's Care Plan dated 11/16/23, revealed a problem initiation on 3/27/23 resident requires assistance with ADL care. Resident #8's care plan showed targeted care to Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. During an interview and observation on 12/10/23 at 11:15 a.m., Resident # 8 was observed with long fingernails, approximately half an inch. He said he prefers that his fingernails were cut short. He said sometimes staff cuts his fingernails for him. He said he did not remember the last time they were cut. During an observation on 12/11/23 at 08:30 a.m., it was observed that Resident # 8 had long fingernails and his nails had yet to be cut. During an interview on 12/12/23 at 11:29 a.m., CNA A said Resident # 8 never refuses care. He said she gave him a shower this morning with no problems. She said that CNAs like herself were responsible to trim the nails of residents. During an observation on 12/12/23 at 11:34 a.m., it was observed that Resident # 8 had long fingernails and his nails had yet to be cut. During an interview on 12/12/23 at 11:37 a.m., with the Director of Nursing she said it was the responsibility of CNAs to complete all ADL care for residents that wereare dependent for care. She said nurses can also do ADL care such as trimming fingernails if a CNA failed to do so. She said she expects staff to provide ADL care for residents that were dependent for care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/23 at 11:37 a.m., with the Administrator he said he expects all staff to ensure that residents that were dependent for ADL care receive the care they deserve. He said it wasis important to ensure that residents nails were cut to prevent infection. He said that the facility does not have a nail care policy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46929 Based on observation, interview, and record review, the facility failed to ensure the residents environment remained free of accident hazards for 1 of 5 residents (Resident #30) reviewed for accident hazards. The facility failed to ensure an oxygen cylinder found in Resident #30's room was properly stored. This failure could place residents at risk of injury. Findings included: Record review of Resident #30's face sheet, dated 12/12/23, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Record review of Resident #30 significant change MDS assessment, dated 10/18/23, indicated she had a BIMS of 15, which indicated intact cognition. The MDS further indicated she did not receive oxygen therapy. Record review of Resident #30's physician's orders, dated 12/12/23, indicated Resident #30 did not have an order for oxygen therapy. During an observation and interview on 12/10/23 at 11:56 AM., Resident #30 was sitting in her wheelchair at her bedside in her room. There was a portable oxygen tank in the corner of her room leaning against the wall next to her air conditioner. There was no caddy or oxygen rack present. Resident #30 said the oxygen tank was not her's and she did not use oxygen at all. During an observation on 12/11/23 at 08:35 AM, the portable oxygen tank was still in Resident #30's room and was leaning against the wall next to the air conditioner. There was no caddy or oxygen rack present. During an observation on 12/11/23 at 10:56 AM, the portable oxygen tank was still in Resident #30's room, leaning against the wall next to the air conditioner. There was no caddy or oxygen rack present. During an observation on 12/11/23 at 03:16 PM, the portable oxygen tank was in Resident #30's room, leaning against the wall next to the air conditioner. There was no caddy or oxygen rack present. During an interview on 12/12/23 at 11:07 AM, LVN F said she thought Resident #30 was initially on oxygen when she admitted but she does not use it anymore. She said she thought hospice left a tank in there and no one thought to remove it. She said it was off in the corner of the room and no one noticed it. She said the charge nurses were responsible for ensuring the oxygen tanks were not left freestanding in the resident rooms. She said it could fall over and it could become a torpedo due to the pressure of the gas. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/23 at 11:11 AM, ADON G and ADON H said the oxygen tank should not be in the resident's room. They said the oxygen tank could explode, or it could fall over and hurt someone. They said they were unsure why the tank was in there because Resident #30 did not have an order for oxygen. During an interview on 12/12/23 at 11:15 AM, the interim DON said she was unsure why the oxygen tank was left in Resident #30's room. She said she expected the oxygen tank to be stored in a caddy. She said it could fall over and hurt a resident. She said the nurses and the ADONs were responsible for ensuring the proper storage of the oxygen tanks. During an interview on 12/12/23 at 11:21 AM, the Administrator said they did an inservice on 12/11/23 regarding oxygen storage and everybody knew the oxygen tank should have been taken out of the resident's room. He did not expect the tank to be stored without a caddy. He said the tanks could become a torpedo and cause injury. He said all staff were responsible for ensuring that the tanks were stored properly. He said it was ultimately the administrator's responsibility to ensure the oxygen tanks were stored properly. Record review of the facility's undated policy, Oxygen Storage, stated: 1. Oxygen cylinders must be stored in racks with chains, sturdy portable carts, or approved stands . .8. Oxygen cylinders shall not be stored in any resident room or living area . .10. Oxygen cylinders should never be left free-standing .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47339 Based on interviews and record reviews, the facility failed to utilize the services of an RN for 8 consecutive hours 7 days a week for 9 days out of 90 days reviewed for RN coverage. The facility failed to have an RN coverage for 8 consecutive hours 7 days a week on September 4,2023, September 5,2023, September 9,2023, October 2, 2023, October 3, 2023, October 4, 2023, October 12, 2023, October 13, 2023, and October 18, 2023. These failures could place all residents at risk for their clinical needs not being met. Findings included: Review of the facility punch detail report dated 9/1/23-12/11/23 revealed the facility did not have the services of an RN for eight consecutive hours on the following dates: September 4,2023, September 5,2023, September 9,2023, October 2, 2023, October 3, 2023, October 4, 2023, October 12, 2023, October 13, 2023, and October 18, 2023. During an interview on 12/12/23 at 12:01 PM the Interim DON said her first day here was on 10/23/23. The Interim DON said she was not aware of the RN's needing to be 8 hours of consecutive time per day. She said she needed to go over the schedule and change the RN's hours around to meet the 8 hours of consecutive coverage per day. During an interview on 10/19/23 at 12:45 p.m., the Administrator stated it was the Administrator's and DON's responsibility for ensuring the facility complied with RN coverage regulations. He said their main issue was that they have not had a permanent DON for the last 2 to 3 months until the interim DON. Said they were in the process of hiring a permanent DON. He said he did not know there had not been 8 consecutive RN coverage on those days. The Administrator said they would have to look at the current RN's schedule and readjust the scheduling to meet the 8 consecutive hours of coverage needed daily. The Administrator said the effect on the residents of not having an RN on duty for 8 consecutive hours a day, 7 days a week may be the residents could suffer negative outcomes from care provided. Record review of facility policy titled Nursing Services and Sufficient Staff dated 4/10/22 revealed: It is the facility policy of the facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment. 8. Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

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	676007	A. Building B. Wing	12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assures the accurate acquiring, receiving, dispensing, and administering of medications for 1 of 4 residents (Resident #35) and reviewed for pharmacy services. The facility failed to ensure Resident #35's Diphenhydramine Cream 2% was available to be administered. The facility did not ensure medications were properly administered to Resident #35 on 12/11/23. LVN F signed the medication administration record that she had administered Resident #35's Diphenhydramine Cream 2% when the medication was not in the facility. These failures could place residents at risk for the unsafe administration of medications, not receiving prescribed doses of ordered medications and not receiving the intended therapeutic benefit of the medications. Findings included: Record review of facility face sheet dated 12/11/23 indicated Resident # 35 was a[AGE] year-old female admitted to facility on 04/09/2019 with the most recent admission on 04/21/2022. Resident #35's diagnoses included type 2 diabetes mellitus (problems with blood sugar), Morbid obesity (overweight), and dermatophytosis (infection of the hair, skin or nails). Record Review of the comprehensive care plan dated 04/26/2023 indicated Resident # 35 had derm/rash and to provide treatment as ordered. Record review of Quarterly MDS dated [DATE] indicated Resident #35 had a BIMS of 15 indicating no cognitive impairment. Record review of physician orders dated 12/09/2023 indicated Resident #35 had an order for Diphenhydramine Cream 2% apply to affected areas topically three times daily at 8am 2pm and 8pm for 1 week. Apply to elbows and back of arms, hands, abdomen, and legs for allergic reaction. During an observation and interview with Resident #35 on 12/10/23 at 11:30 AM, Resident #35 said she had an allergic reaction to a steroid she was taking. Resident showed a rash covering both of her arms and face. Resident #35 said the Nurse Practitioner ordered Diphenhydramine Cream 2% to be applied topically to the rash. Resident #35 said the staff told her they did not have the medication available yet. Record review of Resident #35's medication administration record dated 12/01/23-12/31/23 revealed on 12/11/23 LVN F signed that Diphenhydramine Cream 2% had been administer to Resident #35 at 8:00 AM and 2:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/11/23 at 3:40 PM LVN F said she had signed the medication administration record that she had administered Diphenhydramine Cream 2% to Resident #35 at 8:00 AM and 2:00 PM but she had not administered the medication yet. Surveyor had asked to see the medication, and LVN F went to her medication cart and did not find the medication. LVN F had then been observed going to the medication room and did not find the medication. LVN F had then been observed going to the supply room and did not find the medication. LVN F then said she did not think they had the medication in the facility. During an observation and interview on 12/11/23 at 4:00 PM LVN F said she now had the Diphenhydramine Cream 2% in the facility and would administer the medication to Resident #35. During an interview on 12/11/23 at 4:01 PM the Interim DON said she had sent someone to the store to get Diphenhydramine Cream 2% and the medication was now available for Resident #35. The Interim DON said she had started in-services and provided 1 to 1 education with the nurses that had signed the medication administration record without having the medication. During an interview on 12/12/23 11:33 AM LVN F said she has been employed here for about a year. She said she was supposed to look at the medication administration record and then follows the rights of medication administration. LVN F said that she was supposed to sign the medication administration record after she administers the medication. LVN F said she went to administer the medication between 6:00am-6:30am on 12/11/23 but Resident #35 was already up so she was not able to administer the medication. LVN F said she made a bad judgement and signed the medication administration record before administering the medication and had just assumed the medication was on the med cart. LVN F said a staff member went and picked up the medication from the store on 12/11/23 after she could not locate the medication. LVN F said there were no other medications that she signed for that had not been administered. LVN F said she had been trained and received in-services regarding medication administration but had just made a bad judgement call. During an interview on 12/12/23 at 12:01 PM the Interim DON said the nurses should have placed Resident #35's medication order on hold, and notified the facility that medication was not available so that the medication could be obtained. The Interim DON said she had not been notified that Resident #35's medication was not available. She said all new orders are gone over daily in the morning meeting and nurses are supposed to notify her if they did not have the medication ordered. The interim DON Said her expectation was medication is available and that all physician orders were followed. During an interview on 12/12/23 at 12:22 PM the Administrator said in general the nurse was responsible for making sure medications were available. He said the nurse was to notify the DON or ADON to make sure they can get the medication in the facility. The Administrator said his expectation for nurses was to make sure the medication was in the building and nurses were not to sign for a medication unless it had been administered. Record review titled Medication Administration Skills Review dated 10/25/23 revealed LVN F had met expectations for the medication administration performance criteria. Record review of facility Medication Error Report dated 12/11/23 at 4:00 PM revealed Diphenhydramine Cream 2% ordered for Resident #35 was not available. The corrective action taken: new order obtained to restart Diphenhydramine hcl Cream 2% three times a day for 7 days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Medication-Treatment Administration and Documentation Guidelines dated 4/6/23. 4. Administer the medication according to the physician order. 5. Document e-signature for medications and treatments administered on the EMAR or ETAR immediately following administration.7. Medications or treatments that were not administered should be documented as not administered on the EMAR/ETAR with the reason for the not administration. 9. Check the E Box list for medication not available. If medication is not available verify availability with pharmacy. 10. Notify the physician when medication or treatment will be available, provide information regarding medications in E Box and document physician response and/or physician. 12. Review the EMAR and ETAR after each medication and treatment administration is completed and prior to the end of the shift to validate documentation is completed and supports services provided according to physician orders. 14. Complete a Medication Error Report for medication administration discrepancies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 45643 Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation in that: 1. Potatoes were stored on the floor. 2. Food items were not labeled and dated. These failures could place residents who received meals from the kitchen at risk for food borne illness. The findings were: During an observation on [DATE] at 10:00 a.m., during the initial tour of the kitchen it was observed that multiple items were not labeled or dated inside the kitchen refrigerator. It was observed that food was stored less than 6 inches off the floor. Inside the refrigerator a large pan of pancakes were covered with foil with no label or date. Three salads were stored in bowls with plastic wrap and no label or date. A bag of green onions was stored in a plastic bag with no date or label. A bag of vacuum sealed lettuce was stored in the refrigerator not labeled or dated. Potatoes were stored in a carboard box sitting on the floor. Two boxes were stacked on top of each other. During an interview on [DATE] at 11:37 a.m. with the Director of Nursing, she said she expects that kitchen staff follow food storage policies. She said she expects staff to label and date food items stored in the kitchen. She said residents could be placed at risk fir foodborne illness if they consumed expired foods. She said it was not acceptable to store foods on the floor and staff were to follow state and federal regulations. During an interview on [DATE] at 11:43 a.m., with the Administrator he said he expects his staff to follow facility policies which include food storage in the kitchen. He said kitchen staff were responsible to label and date foods stored in the kitchen that were for the resident's consumption. He said that no food can be stored on the floor of the kitchen, and it must be at least 6 inches off the floor. He said residents could be placed at risk for illness if food is not handled properly. During an interview on [DATE] at 1:00 p.m. with the Dietary Supervisor she said that she expects her staff to follow all facility policies. She said the potatoes that were observed sitting in cardboard boxes on the floor should not have been left sitting there. She said they needed to be stored on a shelf off the floor. She said staff know to label and date food items in the kitchen. She said that they will do better next time. She said that residents could be placed at risk for illness if food handling precautions are not taken. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility document revised [DATE]th of 2017, Dry food and supply storage provided by the Administrator revealed that, Slatted shelving that allows for air-circulation is recommended. Items must be stored at least 6 off the floor. Foods should be off the floor and clear of ceiling sprinklers, sewer pipes and vents. This allows for easy cleaning and discourages pest harborage. Record review of the Texas Food Establishment Rules, [DATE], S228.75(g) Ready-to eat, time/temperature controlled for safety food, date marking. (2) Refrigerated, ready-to-eat, time/temperature controlled for safety food prepared and packaged by a food processing plant shall be clearly be marked at the time the original container is opened in a food establishment and held at a temperature of 41 degrees Fahrenheit or less if the food is held for more than twenty four hours. Record review of the Texas Food Establishment Rules (TFER), [DATE], S228.66 Preventing Food and Ingredient Contamination. (b) Food storage containers, identified with common name of food.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46929 Based on interview and record review, the facility failed to follow guidelines for mandatory submission of staffing information based on payroll data in a uniform format. The facility failed to submit direct care staffing information on the schedule specified by CMS (Centers for Medicare and Medicaid Services), but no less frequently than quarterly for 1 of 4 quarters reviewed for payroll data information. (Quarter 3 2023) The facility failed to submit staffing information to CMS for the 3rd quarter of the fiscal year 2023. This failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feeling of well-being within their living environment. Findings included: Record review of the facility's Civil Rights form (3761) dated 12/11/23 indicated the facility had the following current staff (full and part time): 6 RNs 19 LVNs 31 Direct Care Staff 9 Dietary 8 Housekeeping and Laundry 36 All Others During an interview on 12/11/23 at 09:22 AM, The Regional Director of Operations said that someone at the corporate office was responsible for ensuring the PBJ information was submitted. During an interview on 12/11/23 at 12:32 PM, the Regional Director of Operations said he made a phone call and was waiting to hear back, he said he had nothing to provide this surveyor with at that time. He said he knew the PBJ information was submitted because he reviewed it before it was sent, but he was unsure of the specific date it was turned in. During an interview on 12/11/23 at 03:25 PM, the Regional Director of Operations said that he received an email from the corporate office that the staffing was submitted but had an error and was not caught. He said that it was likely that the PBJ information was not submitted because the corporate office did not catch the error. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/12/23 at 11:21 AM, the Administrator said the PBJ reporting was handled by the corporate office. He said he made sure the staffing hours were sent up to the corporate office and they take care of the PBJ from there. During an interview on 12/12/23 at 11:30 AM, the Regional Director of Operations said he had not heard anything else from the corporate office. He said it was likely that the error was not caught and the office did not resubmit and fix the error. Record review of the CMS PBJ Staffing Date Report (payroll-based staffing), CASPER Report (Certification and Survey Provider Enhanced Report) 1705 D FY Quarter 3 2023 (April 1 - June 30), dated 12/06/23, indicated the following entry: .Failed to submit data for the quarter . Triggered . Triggered=no data submitted for the quarter . Record review of the facility's policy, Nursing Services and Sufficient Staff, dated 04/10/2022, stated: .The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview, and record review, the facility failed to 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 for 1 of 3 residents (Resident #39) reviewed for infection control practices. The facility failed to ensure CNA B changed her gloves and performed hand hygiene while providing incontinent care to Resident #39. These failures could place residents and staff at risk for cross contamination and the spread of infection. Findings included: Record review of Resident #39's face sheet dated 12/12/23 indicate he was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of intracranial injury (a physical induced brain injury causing damage), high blood pressure, cellulitis (a bacterial infection involving the skin), and convulsions (involuntary movement of the body associated with brain disorders). Record review of Resident #39's quarterly MDS dated [DATE] indicated he had a BIMS score of 7 which indicated he had severe cognitive impairment. The MDS also indicated Resident #39 required total assistance with transfers, bed mobility, bathing, and toileting, and could eat independently. The MDS also indicated Resident #39 was always incontinent of bowel and bladder. Record review of Resident #39's care plan last revised on 08/25/23 indicated he had an activities of daily living self-care deficit with a goal to remain a sense of dignity by being clen, dry, odor free, and well groomed, and interventions for staff to provide total assist with toileting. The care plan also indicated Resident #39 was incontinent of bowel/bladder. Record review of the validation checklist for hand hygiene dated 6/12/23 indicate CNA B was proficient in completing hand hygiene. Record review of the nursing peri-care skills check-off dated 6/12/23 indicate CNA B was proficient in completing peri-care. During an observation on 12/11/23 at 10:35 AM CNA B and CNA C were in the hallway outside of Resident #39's room. Both CNAs knocked on the door and entered Resident #39's room to provide incontinent care. The CNAs washed their hands and had supplies setup on bedside table. During incontinent care CNA B cleaned Resident #39's peri area and changed gloves but failed to sanitize hands. CNA B cleaned bowel movement from Resident #39's buttocks and failed to change gloves or sanitize prior to grabbing clean brief to place on resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/23 at 10:48 AM CNA B said she should have sanitized her hands before donning new gloves and she forgot to change gloves after washing Resident #39's buttocks. She said this failure could have caused crossed contamination. CNA B said she had been checked off for proficient incontinent care by ADON G and ADON H but unsure of the exact date. During an interview on 12/12/23 at 1:01 PM ADON G said she expected the CNAs to wash or sanitize hands and change gloves between clean and dirty while providing incontinent care. ADON G said her and ADON H were responsible for ensuring the CNAs provide proper incontinent care. She said CNA B was proficient in completing incontinent care, but she was nervous and made the mistake. ADON G said the failure placed Resident #39 at risk for infection. During an interview on 12/12/23 at 1:08 PM the Interim DON said she expected the CNAs to wash hands, sanitize, and change gloves as instructed during incontinent care. She said the ADONs were responsible for ensuring the CNAs were checked off for providing incontinent care properly. The DON said this failure placed Resident #39 at risk for infection. During an interview on 12/12/23 at 01:17 PM the Administrator said he expected the CNAs to use hand sanitizer and practice hand washing per protocol. The Administrator said he was responsible for ensuring the staff were educated on hand washing and infection control. The Administrator said the failure placed a risk of the spreading of infection. Record review of The Policy for Incontinence Care dated 4-17-14 and last reviewed 2/4/2020 indicated: Purpose: To outline the procedure for cleansing the perineum and buttocks after an incontinence episode . Procedure .4. Wash hands .8. If feces present, remove with toilet paper or disposable wipe by wiping from front of perineum toward rectum. Discard soiled materials and gloves. Wash hands. 9. Put on non-sterile, latex-free gloves . Record review of The Hand Hygiene policy dated 11/12/2017 indicated: Policy: The staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .3. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table .When, during resident care, moving from a contaminated body site to a clean body site .