STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676220	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Mesa Health Center	1401 Max Copeland Dr Marble Falls, TX 78654

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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 - Some	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** 42600 Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect, dignity and cared for in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 4 (Resident #46, Resident #56, Resident #76, and Resident #78) of 18 residents reviewed for resident rights. The facility failed to ensure Resident #46 was changed after food was spilled on her clothes after meal service. This failure placed residents at risk for diminished quality of life and at risk for decreased feelings of self-worth and dignity. 1. Review of Resident #56's Face Sheet dated 10/02/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #56's diagnoses included heart failure, severe protein-calorie malnutrition, sleep apnea (breathing pauses while sleeping), hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), hyperlipidemia (high cholesterol), cardiac defibrillator (detects and stops irregular heartbeats), muscle wasting and lack of coordination. Record review of Resident #56's Quarterly MDS dated [DATE] revealed Resident #56 had a BIMS score of 15 indicating resident was intact cognitively. 2. Review of Resident #76's Face Sheet dated 10/02/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #76's diagnoses included displaced fracture of coronoid process of left ulna (traumatic elbow fracture), atrial fibrillation (irregular heartbeat), cerebral infraction (stroke), hyperlipidemia (high cholesterol), hypertension (high blood pressure), gastroesophageal reflux disease without esophagitis (reflux), hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (paralysis and weakness on right side after stroke), muscle wasting, muscle weakness, lack of coordination and need for assistance with personal care. Record review of Resident #76's Quarterly MDS dated [DATE] revealed Resident #78 had a BIMS score of 15 indicating resident was intact cognitively. (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 - Some	3. Review of Resident #78's Face Sheet dated 10/02/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #78's diagnoses included surgery on the digestive system, intestinal obstruction, large intestine abscess, atrial fibrillation (irregular heartbeat), muscle wasting, muscle weakness, lack of coordination, cognitive communication deficit (problems with communication), and need for assistance with personal care. 4. Record review of Resident #78's Quarterly MDS dated [DATE] revealed Resident #76 had a BIMS score of 15 indicating resident was intact cognitively. 5. Review of Resident #46's face sheet dated 10/02/2024 revealed a [AGE] year-old female admitted on [DATE] and had diagnoses of unspecified dementia (condition that causes a decline in cognitive abilities), Parkinson's disease (chronic brain disorder that causes movement problems), cognitive communication deficit (difficulty with communication cause by disruption to cognition) and major depressive disorder (serious mental disorder that affects how a person, feels, thinks and functions). 6. Review of Resident #46's quarterly MDS dated [DATE] revealed a BIMS score of 2 which indicated severe cognitive impairment. Resident #46 required substantial/maximum assistance (more than half the effort) by staff for upper and lower body dressing and personal hygiene. Observation on 09/30/2024 at 1:28 PM, Resident #46 was observed sitting in hallway with food on her pants. Observation on 09/30/2024 at 1:55 PM, Resident #46 was observed sitting in hallway with food on her pants. Observation on 09/30/2024 at 2:12 PM, revealed staff ask Resident #46 if she wanted to lay down. Staff did not ask Resident if she wanted to change her clothes. Observation on 09/30/2024 at 2:24 PM, revealed Resident #46 sat in hallway in her wheelchair and observed with food on her pants. Observation on 09/30/2024 at 3:24 PM, revealed Resident #46 sat in hallway in her wheelchair and observed with food on her pants. Observation on 10/01/2024 at 1:31 PM, revealed Resident #46 sat in hallway in her wheelchair with food on her pants and shirt. Observation of hall trays being passed on 09/30/2024 at 12:33 p.m., revealed that MR C did not knock on Resident #76's door before entering. Observation of hall trays being passed on 09/30/2024 at 12:37 p.m., revealed that LVN D did not knock on Resident #56 and Resident #78's door before entering. An interview with Resident #56 on 10/02/2024 at 9:22 a.m., revealed that staff do not always knock on her door before entering. She said that staff do not knock at least twice a day and that it was usually when her door was open. She said she does not get upset when staff do not knock. She said she would like staff to knock all the time unless she sees the staff and staff see her then it would be silly to knock. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #78 on 10/02/2024 at 9:27 a.m., revealed that staff usually knock before coming into his room. He stated that staff only come into his room without knocking when he pushes the call light. He said they do not come in unauthorized. He said he would like staff to knock all the time unless he has already called them. An interview with Resident #76 on 10/02/2024 at 9:21a.m., revealed that she thought staff always knocked. She said she had not paid much attention to staff knocking before coming in she said now that she had a roommate, she would like staff to knock because there are men and women working at the facility and she was able to close her door and keep staff out with the bathroom door open. She said now she had a roommate and cannot do that and did not want staff to expose her while in the bathroom. She said she would like staff to knock all the time. An interview with MR C on 10/02/2024 at 9:37 a.m., revealed she had been trained on resident rights. She stated the policy was to knock on the resident's door, announce yourself and tell the resident what you are there to do. She said staff were supposed to knock on the resident's door all the time. She said if staff did not knock on the resident door before entering it might surprise them. she stated that she had her hands full and said knock, knock after she entered. She also said she should have said knock, knock and waited for the resident to tell her to come in. An interview with the DON on 10/02/2024 at 9:45 a.m., revealed that she was trained on resident rights. She stated staff were to knock on the resident's door when they are going into the room. She said staff were to knock all the time. She said if staff do not knock on the resident's door the resident may get upset depending on the resident. She also said that even if the resident did not mind it staff do not knock the staff need to give the resident the courtesy of knocking. She stated staff may not have been knocking because they got too comfortable and that they are used to the residents. She said they still needed to knock. An interview with the ADM on 10/02/2024 at 9:53 a.m., revealed staff had been trained on resident rights. He stated that staff should be knocking on the resident's door before entering the room. He stated it was the resident's right to privacy. He stated all staff were to knock before entering a resident's room. He said if staff do not knock the resident may feel embarrassed. He stated that all of management was responsible for monitoring staff were knocking on the residents door. He stated that management monitors it by doing observation rounds. He stated he thought staff were not knocking because they were familiar with the residents. Observation on 10/01/2024 at 2:23 PM, revealed Resident #46 laid in bed with her same clothes with food on her pants and shirt. During an interview on 10/02/2024 at 10:36 AM, SC A stated that after meals residents are supposed to have their clothes changed if they get food on them. She stated that Resident #46 usually spilled food on her clothes. SC A stated she was not sure why Resident #46 was not changed after lunch. During an interview on 10/02/2024 at 10:52 AM, LVN B stated that usually after meals Resident #46 did have food on her clothes. She stated that she would get changed. LVN B stated that residents should not sit with food on their clothes for hours after meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/02/2024 at 11:02 PM, LBSW stated that she expected residents not to have food on their clothes after meals and stated that should have been cleaned up and stated that she would want to be cleaned up. She stated that even if resident was not aware of it, it was not right. During an interview on 10/02/2024 at 12:18 PM, LVN G stated that residents are changed after meal services if that had food on their clothes. She stated that she changed residents as soon as she saw that they had food or would ask other staff to help change the resident. She stated that residents should not sit in the hall for hours with food from lunch on their clothes. During an interview on 10/02/2024 at 1:04 PM, the DON stated that she expected that if residents had food on their clothes that they would be changed. She stated that if staff saw at it, they should change the resident. She stated that the resident could be embarrassed. During an interview on 10/02/2024 at 1:04 PM, the ADM stated that he expected that if residents had food on their clothes after they completed their meal that their clothes be cleaned, or they be changed. He stated that he expected this to happen timely. The ADM stated that this could make the resident feel dirty or sloppy. Record review of Resident Rights dated October 4, 2016, revealed residents have the right to be treated with dignity and respect. The resident also has the right to personal privacy. Review of facility policy titled Resident Rights and Responsibilities, notice of with revision date of 12/2023 revealed resident had the right to a dignified existence.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 4 (Resident #33, Resident #46 and Resident #69,and Resident #433) of 18 residents reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #33's quarterly MDS dated [DATE] accurately reflected her psychiatric/mood disorder. 2. The facility failed to ensure Resident #46's quarterly MDS date 07/21/2024 accurately reflected her psychiatric/mood disorder. 3. The facility failed to ensure Resident #69's quarterly MDS dated [DATE] accurately reflected his psychiatric/mood disorder. 4. The facility failed to ensure Resident #433's admission MDS dated [DATE] accurately reflected her psychiatric/mood disorder. This failure could result in inadequate care due to an inaccurate assessment of psychiatric and mood disorders. Findings include: 1. Review of Resident #33's face sheet dated 10/02/2024 revealed a [AGE] year-old female was admitted on [DATE] and had diagnoses of major depressive disorder (serious mental disorder that affects how a person feels, thinks, and functions in daily life), unspecified macular degeneration (age-related degeneration of vision), and cognitive communication deficit (difficulty with communication that's caused by a disruption in cognition). Review of Resident #33's physician orders dated 08/22/2023 to 09/26/2024 revealed Resident #33 had an order for Venlafaxine indicated for major depressive disorder with a start date of 12/12/2023. Review revealed an order for psych to eval and treat dx: Anxiety with a start date of 08/28/2023. Further review revealed an order for Xanax indicated for anxiety two times a day with a start date of 08/28/2023 and an additional order of Xanax as needed indicate for anxiety with a start date of 09/29/2024 and end date of 10/13/2024. Review of Resident #33's quarterly MDS dated [DATE] revealed depression was selected as an active diagnosis in the last 7 days for Resident #33. Further review revealed anxiety disorder was not selected. Review of Resident #33 psychiatric progress note dated 11/2/2023 reflected major diagnoses as major depressive disorder and GAD (generalized anxiety disorder). Review of Resident #33 psychiatric progress note dated 07/29/2024 revealed major diagnoses as major depressive disorder and GAD (generalized anxiety disorder) with an anxious mood during the session. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #33 care plan dated 08/29/2023 revealed resident #33 received an anti-anxiety medication related to anxiety disorder. 2. Review of Resident #46's face sheet dated 10/02/2024 revealed a [AGE] year-old female admitted on [DATE] and had diagnoses of unspecified dementia (condition that causes a decline in cognitive abilities), Parkinson's disease (chronic brain disorder that causes movement problems), cognitive communication deficit (difficulty with communication cause by disruption to cognition) and major depressive disorder (serious mental disorder that affects how a person, feels, thinks and functions). Review of Resident #46's physician orders 02/12/2022 to 09/20/2024 revealed Resident #46 had an order for Alprazolam indicated for anxiety with a start date of 04/24/2024. Review revealed an order for citalopram indicate for depressive disorder and anxiety with a start date of 10/03/2023. Review of Resident #46's quarterly MDS dated [DATE] revealed depression was selected as an active diagnosis in the last 7 days. Further review revealed that anxiety disorder was not selected. Review of Resident #46's psychiatric progress note dated 07/19/2024 revealed resident's current psychiatric medications were citalopram and alprazolam. Review of Resident #46's care plan dated 05/26/2023 revealed resident was taking an anti-anxiety medication related to anxiety disorder. 3. Review of Resident #69's face sheet revealed a [AGE] year-old man admitted on [DATE] and had diagnoses of unspecified sequela of cerebral infarction various symptoms after a stroke), type 2 diabetes (chronic condition that occurs when the body does not properly use insulin to process blood sugar), dysphagia (difficulty swallowing), and cognitive communication deficit (difficulty with communication cause by disruption to cognition). Review of Resident #69's physician orders dated 02/06/2024 to 09/10/2024 revealed Resident #46 had an order for alprazolam indicated for anxiety with a start date of 09/01/2024 and an order for citalopram indicated for anxiety with a start date of 02/11/2024. Review of Resident #69's quarterly MDS dated [DATE] revealed there were no psychiatric/mood disorders selected under active diagnoses for the last 7 days. Review of Resident #69's psychiatric progress note dated 06/18/2024 revealed resident's major diagnoses was anxiety and vascular dementia. Review of Resident #69's care plan dated 08/21/2024 revealed resident was taking anti-anxiety medication related to anxiety disorder. Further review revealed Resident #69 was taking an anti-depressant related to depression. 4. Review of Resident #433 face sheet revealed a [AGE] year-old female admitted on [DATE] and had diagnoses of anoxic brain damage (occurs is when brain is deprived of oxygen), post-traumatic stress disorder (mental condition that can develop after a person experiences or witnesses a traumatic event), and bipolar disorder (a mental illness that causes extreme shifts in mood, energy and activity levels). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #433's physician orders dated 09/16/2023 to 09/27/2024 reveled and order for buspirone indicated for anxiety with a start date of 09/16/2024, an order for clonazepam (as needed) indicated for anxiety with a start date of 09/27/2024 and end date of 10/11/2024, an order for divalproex indicated for anxiety with a start date of 09/30/2024, and an order of l-methyl folate indicated for depressive disorder with a start date of 09/22/2024. Review of Resident #433's hospital discharge orders date 09/16/2024 revealed resident admitted to facility with orders for buspirone, clonazepam, and divalproex. Review of Resident #433's admission MDS dated [DATE] revealed bipolar disorder and post-traumatic stress disorder selected under active psychiatric/mood disorder diagnoses. Further review depression and anxiety were not selected. Review of Resident #433's care plan date 09/17/2024 revealed resident received an anti-anxiety medication related to anxiety disorder. Further review revealed resident was at risk for depression with interventions to administer medications as ordered. Review of Resident #433's initial psychiatric evaluation dated 09/19/2024 revealed resident's mood during assessment was depressed and anxious. Further review revealed diagnoses of depression. Review of Resident #433's admission history and physical physician note dated 09/18/2024 revealed Resident #433 had diagnoses for mixed anxiety and depressive disorder and a diagnosis for other specified anxiety disorder. During an interview on 10/02/2024 at 11:02 AM, LBSW stated that Resident #46 was prescribed citalopram for depressive disorder and anxiety. LBSW stated that resident has restlessness and agitation. LBSW stated that did not see mixed anxiety on Resident #46's diagnoses list. LBSW stated that she was not sure who was responsible to add information to a resident's diagnosis list. LBSW stated that she was not sure who was responsible to ensure psychiatric diagnoses were added to the MDS. During an interview on 10/02/2024 at 12:18 PM, LVN G stated that when a new admission or order was received, she would check to see that there was a corresponding diagnosis for that order. She stated that if a resident had an order indicated for anxiety, they should have a diagnosis of anxiety. She stated that she would get updates about diagnosis from the admissions nurse, MDS or DON. During an interview on 10/02/2024 at 12:24 PM with MDSN H, she stated that the resident should have a corresponding diagnosis on their diagnoses list if they have an order indicated for those diagnoses. She stated that diagnoses could come from the hospital or provider's progress notes. MDSN H stated she was responsible for adding diagnoses to a resident's diagnoses list. She stated that if a resident received a medication for anxiety or depression it should be on the MDS. MDSN H stated that Resident #46's alprazolam was indicated for anxiety, and she did not have an anxiety diagnosis listed and it was not on her MDS under psychiatric and mood disorders. MDSN H stated that there was not any additional staff who review the MDS to ensure all diagnoses were added and it was only her. She stated that it is important that all diagnoses be on the MDS for accuracy. MDSN H stated that she reviewed progress notes from providers for any updated diagnoses or information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/02/2024 at 10/02/2024 at 1:01 PM, the DON stated that MDSN H was responsible for ensuring diagnoses were added to a resident's diagnoses list, but that the NP or MD would also add diagnosis. She stated that she expected a resident to have a corresponding diagnosis on their diagnosis list if they received a medication indicated for that diagnosis. The DON stated that she also expected that diagnoses to be listed on the resident's MDS. She stated that the IDT care planned information, and she expected the MDS and care plan to match. During an interview on 10/02/2024 at 1:14 PM, the ADM stated that the nurse was responsible to ensure the diagnosis was added to the diagnosis list. He stated that the DON, ADON audit the diagnosis list. The ADM stated that he expected the information on the care plan and MDS to match. He stated that he would expect that if a resident had an order for a medication indicated for depression or anxiety that they have an associated diagnosis. The Team Coordination on 10/02/2024 at 11:20am asked ADM for the policy related to accuracy of assessments. The policy was not provided. 49097

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview and record review, the facility failed to provide an ongoing program of activities based on the comprehensive assessment, care plan and the preferences of each resident to meet the interests of and support the physical, mental, and psychosocial well-being for 2 of 5 (Resident #46 and #71) reviewed for activities . The facility failed to develop an ongoing activity program for Resident #46 and Resident #71. This failure placed residents at risk of not having their recreational and social needs met. Findings included: 1. Review of Resident #46's face sheet dated 10/02/2024 revealed a [AGE] year-old female admitted on [DATE] and had diagnoses of unspecified dementia (condition that causes a decline in cognitive abilities), Parkinson's disease (chronic brain disorder that causes movement problems), cognitive communication deficit (difficulty with communication cause by disruption to cognition) and major depressive disorder (serious mental disorder that affects how a person, feels, thinks and functions). Review of Resident #46's physician orders 02/12/2022 to 09/20/2024 revealed Resident #46 had an order that she may participate in social activities as tolerated. Review of Resident #46's quarterly MDS dated [DATE] revealed a BIMS score of 2 which indicated severe cognitive impairment. Review of Resident #46's care plan dated 06/08/2023 revealed Resident #46 was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. Interventions included for staff to invite to scheduled activities. Resident #46's care plan revealed that she required assistance or escort to activity functions. Further review revealed Resident #46 was taking an antidepressant related to depression and an antianxiety medication related to anxiety disorder and interventions included to take to activities. Review of Resident #46's activity admission assessment dated [DATE] revealed resident #46 enjoyed listening to music and church and bible study. Additional comments included that resident should be invited and reminded and assisted to activities. Review of Resident #46 quarterly evaluation dated 08/21/2024 revealed Resident #46 will attend if brought to activities and watches. Review of Resident #46's individual resident daily participation record for 08/2024 revealed resident did not participate in any activities from 08/22/2024 to 08/31/2024. Review of resident daily participation record of 09/2024 revealed resident attended religious services on 09/30/2024 and did not attend any additional activities on 09/30. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #71's face sheet revealed a [AGE] year-old woman admitted on [DATE] and had diagnoses of unspecified dementia (condition that causes a decline in cognitive abilities), generalized anxiety disorder (a mental disorder that causes people to experience excessive, persistent, and uncontrollable worry) and cognitive communication deficit (difficulty with communication that's caused by a disruption in cognition). Review of physician orders for Resident #71 dated 07/29/2024 to 09/27/2024 revealed an order that Resident #71 may participate in social activities as tolerated. Review of Resident #71's quarterly MDS dated [DATE] revealed a BIMS score of 3, which indicate severe cognitive impairment. Review of Resident #71's care plan dated 07/30/2024 revealed Resident #71 was taking an antidepressant related to depression and an antianxiety medication related to anxiety disorder and interventions included to take to activities. Review of Resident #71's admission activity evaluation dated 06/05/2024 revealed resident had interest in crafts, music, singing, watching TV and movies, with assessed needs that included to offer activities to keep her occupied. Resident #71 did not have individual resident daily participation record for the past two months (August 2024 and September 2024). Review of September 2024 activity calendar revealed 09/30/2024 activities as mail run, bib study/music group, bingo and activities. Review of October 2024 activity calendar revealed 10/01/2024 activities as mail run, drum team, nails in room, movie, and TV. 10/02/2024 activities were listed as mail run, front lobby games, and bingo. Observation on 09/30/2024 at 9:53 AM, revealed Resident #71 attempted to stand in hallway and walk away from her wheelchair. Observation on 09/03/2024 at 10:38 AM, revealed Resident #46 sat in the hallway in her wheelchair. Resident was observed attempting to talk to individuals and staff that walked by. Observation on 09/30/2024 at 1:26 PM, revealed Resident #71 sat in her wheelchair in hallway. Observation on 09/30/2024 at 1:28 PM, revealed Resident #46 sat in her wheelchair in the hallway. Resident held a baby doll. Observation on 09/30/2024 at 1:55 PM, revealed Resident #46 and Resident #71 sat in hallway in their wheelchairs. Observation on 09/30/2024 at 2:10 PM, revealed Resident #71 attempted to stand up from her wheelchair. Observation 09/30/2024 at 2:24 PM, revealed Resident #46 sat in hallway in her wheelchair with her baby doll and Resident #71 sat in her wheelchair. (continued on next page)

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Granite Mesa Health Center	1401 Max Copeland Dr Marble Falls, TX 78654

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation 09/30/2024 at 3:26 PM, revealed Resident #46 sat in hallway in her wheelchair. Observation on 09/30/2024 at 3:27 PM, revealed Resident #71 sat in the hallway in her wheelchair. Observation on 10/01/2024 at 9:51 AM, revealed Resident #71 asleep in her room. Observation on 10/01/2024 at 10:39 AM, revealed Resident #46 sat in hallway in her wheelchair with her baby doll. Observation on 10/01/2024 at 11:44 AM, revealed Resident #46 and Resident #71 sat in hallway in their wheelchairs. Observation on 10/01/2024 at 1:31 PM, revealed Resident #46 and Resident #71 sat in hallway in their wheelchairs. Observation on 10/01/2024 at 1:33 PM, revealed AD F say there was activities in the dining room and encouraged resident is near nurses station to attend. AD F did not walk down the hallway and ask Resident #71 or Resident #46 if they wanted to attend. Observation on 10/01/2024 at 2:23 PM, revealed Resident #46 and Resident #71 sat in hallway in their wheelchairs. Observation on 10/02/2024 at 10:33 AM, revealed Resident #46 sat in hallway in her wheelchair with her baby doll. Observation on 10/02/2024 at 10:35 AM, revealed Resident #71 sat in hallway in her wheelchair. During an interview on 10/01/2024 at 10:11 PM, Resident #71's FM stated that the facility had games if people were interested in them and stated that Resident #71 was much for playing games. He stated that Resident #71 used to enjoy housework such as cooking and watched certain TV shows in the afternoon. FM stated that he was unsure what activities Resident #71 participated in or attended. During an interview on 10/02/2024 at 10:32 AM, SC A stated that the facility has bingo, painting, things to do in the dining room and church music. She stated that Resident #46 was taken to the dining room if there was a music activity. SC A stated that Resident #46 usually watches activities. SC A stated that Resident #46 liked to sing, and she did not participate in any activities yesterday. SC A stated that when Resident #46 sat in the hall she usually just held her baby doll. SC A was not aware of any staff playing music for Resident #46 in hall or in her room. During an interview on 10/02/2024 at 10:34 AM, SC A stated that resident goes to therapy and walks with therapy as what she usually does day to day. SC A stated that she may go to church and stated that the church/music is once a week. SC A stated that Resident #71's FM visits. SC A stated that when Resident #71 is in the hallway she screams at people and sits and watches the staff most of the day when she's in the hallway. SC A stated she was not sure why Resident #71 was in the hallway. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/02/2024 at 10:44 AM, CNA E stated that there were activities for residents to do such a drumming group, music and bingo. She stated that CNA would help residents get to the activity and bring them back after there were finished. She stated that if a resident were sitting in the hallway she would ask if there was something they wanted to do or offer them something to do. During an interview on 10/02/2024 at 10:52 AM, LVN B stated that the facility had activities such as bingo, church, singing and one on one visits with AD F. She stated that Resident #46 attended church services as activities she attended, and she was unsure how often Resident #46 was offered to attend activities. LVN B stated that when Resident #46 sat in the hallway she is offered fluids, asked about her needs and talked with. LVN A stated that Resident #46 does not like to be by herself. LVN B stated that it was important to residents to engage in activities for socialization, mental health and physical health. LVN B stated that Resident #71 liked to attend bingo and church. She stated that she had a puzzle for her to do that staff put out for her. LVN B stated that Resident #71 did not have the puzzle right now. LVN B stated that Resident #71 does not like to be in her room by herself and likes to be around people. During an interview on 10/02/2024 at 11:02 AM, LBSW stated that she was not sure what Resident #71 liked to do that she did not do a whole lot. LBSW stated that she was not sure what Resident #71 did when she says in the hallway or why she was sitting in the hallway. LBSW stated that she was not sure what Resident #46 liked to do and why she sat in the hallway. LBSW stated that Resident #46 say in the hallway and watched the world go by. She stated that she thought Resident #46 attended music activities and parties. LBSW stated that it was important for residents to participate in activities because it gave them socialization and helped with mood and depression. During an interview on 10/02/2024 at 11:18 AM, AD F stated that she has been the activity director for about 6 months. She stated that Resident #46 loved music, liked to sing and attend church music service on Mondays. She stated that Resident #46 also liked to color and her baby doll. She stated that Resident #46 was confused, and a fall risk and that staff needed to keep an eye on her and that was why she sat in her wheelchair with her baby doll. AD F stated that Resident #46 liked to talk with everyone and is social. AD F stated that Resident #71 was not able to sit and stay focused but liked to watched bingo and liked to talk. She stated that Resident #71 liked to color and listen to music. She stated that she tried to bring Resident #71 into activities. AD F stated that when Resident #71 was in the hallway she tried to stand up. AD F stated that there were activity pages for Resident #71 to do when she sat in the hall. AD F stated that the nurse would put soothing music on. AD F stated that the activity pages were in her office and not on the hallway. She stated that Resident #71 like magazines as well. AD F stated that she recently started to keep a log of activities residents attended. She stated that it was important to residents to participate in activities for cognition, mobility socialization, and all-around well-being. AD F stated that participation in activities kept residents active and well. During an interview on 10/02/2024 at 1:04 PM, the DON stated that usually Resident #71 participated in bingo or did coloring page and was encouraged to stay in communal areas due to a history of falls. She stated that Resident #46 did not like to be alone and has been a social person. The DON stated that she expected residents to be offered to go to activities or encouraged to go. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/02/2024 at 1:12 PM, the ADM stated that he expected AD F maintained activities that were engaging and that they enjoyed. He stated that activities and preferences were discussed during resident council meetings. ADM stated that if residents were unable to participate in group activities, he expected that they be provided with coloring or word searches. The ADM stated that he expected residents who sat in the hallway were offered activities that interested them. Review of facility policy titled Activities Programming with revision date 12/2023 revealed it is the policy of this facility to ensure that activities are available to meet resident needs and interests that support the physical, mental, and psychological well-being of the resident. Activities are defined as any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 50176 Based on interviews, observations, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 19 of 94 days reviewed for RN coverage. The facility failed to ensure they had an RN scheduled on duty for 19 days (07/04/2024, 07/08/2024, 07/09/2024, 07/14/2024, 07/22/2024, 08/05/2024, 08/19/2024, 08/30/2024, 09/03/2024, 09/04/2024, 09/10/2024, 09/16/2024, 09/17/2024, 09/18/2024, 09/24/2024, 09/25/2024, 09/26/2024, 10/01/2024, and 10/02/2024) and failed to ensure the DON was not acting as the charge nurse when the facility had an average daily occupancy of more than 60 residents. This failure placed residents at risk of missed nursing assessments, interventions, care, and treatment. Findings included: Review of the daily staffing for July 1, 2024, through October 2, 2024, reflected zero hours worked by an RN on the following days: -07/04/2024, -07/08/2024, -07/09/2024, -07/14/2024, -07/22/2024, -08/05/2024, -08/19/2024, -08/30/2024, -09/03/2024, -09/04/2024, -09/10/2024, -09/16/2024, -09/17/2024, (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-09/18/2024, -09/24/2024, -09/25/2024, -09/26/2024, -10/01/2024, and -10/02/2024. During an observation on 10/01/2024 and 10/02/2024, the staffing schedule posted at the nursing station revealed 12-hour shifts for nursing staff. There was no RN listed on the schedule for 10/01/2024 and 10/02/2024. During an interview on 10/01/2024 at 02:09 PM, LVN B stated RNs worked 12-hour shifts and a RN was available at least 8 consecutive hours in the day. When the regular RNs were not available, the DON served as the nurse for that day. LVN B was not aware of any residents going without their needs being met due to a RN not being scheduled because the DON was available to meet those needs. During an interview on 10/01/2024 at 02:16 PM, SC A stated she made the schedule for the facility. There were two RNs that worked 12-hour shifts and if they were not available, then the DON worked as the RN for that shift when available. SC A sent a What's Up chat to let staff know when there was not a RN available in the facility. When a RN was not at the facility, she called the DON to cover the shift. SC A had never known a time when a resident needed care or services by a RN and did not receive care because the facility called an agency RN through a service called Dynamic access that provided resident care in the absence of a scheduled RN. During an interview on 10/02/2024 at 08:39 AM, the DON stated they do not have a facility policy for RN coverage. They used the regulation language in Appendix PP, which stated, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. The DON stated there are two full time RNs and one RN that worked PRN. The DON stated that she worked as the RN on shift when there was not a RN available for the 8 consecutive hours each day as often as she could, but she was not always available. DON stated she was aware there was supposed to be 8 hours of RN coverage every day in the facility, which was why she worked to cover those hours. The DON stated she had interpreted the policy differently and did not know her 8 hours could not count as the required RN 8 hours since the facility census was over 60. The DON stated the current census was 86 and the average census was around 80 for the past three months. The DON did not believe she was working as the charge nurse when she was working in the facility as the only RN. The DON did not believe the charge nurse needed to be a RN. The DON stated there was not a potential negative outcome to residents for not having a RN scheduled because her LVNs were very well trained. The DON stated that it was difficult to hire an RN to work at the facility. The DON reviewed the staffing schedule for 07/01/2024, through 10/02/2024 and agreed there was not a scheduled RN on 19 days. The DON stated she did not work on 07/04/2024 when no RN was scheduled that day. The DON stated she wanted to consider a waiver for RN coverage. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/02/2024 at 09:22 AM, the ADM stated they do not have a facility policy for RN coverage. They used the regulation language provided by CMS, which stated, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. The ADM stated he was aware there was supposed to be 8 hours of RN coverage every day in the facility, which was why the DON worked to cover those hours, when a RN was not scheduled. The ADM stated he had interpreted the policy differently and did not know the DON's hours could not count as the required RN 8 hours. The ADM stated that the DON tried to cover the shifts when the usual two full time RNs were not available for the 8 hours. For the last three months, there were 17 days when there was not a RN on schedule and the DON covered most of those days. The ADM stated he did not think of the DON as the charge nurse and did not think the charge nurse had to be an RN. The ADM stated potential adverse outcome to residents for not having RN on shift was decrease in the quality of care. The ADM stated their census was over 80 and he agreed that there was no RN on the schedule for 17 days during July-September and no RN on schedule 10/01/2024 and 10/02/2024. The ADM stated he had been trying to hire an RN for the last several months with no success. He had an ad on Indeed and one person accepted the job, but then took a different job offer before starting. The ADM stated he wanted to consider a waiver for RN coverage.