STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676248	A. Building B. Wing	05/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Founders Plaza Nursing & Rehab	721 S Hwy 78 Wylie, TX 75098

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observation, interview, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 2 (Resident #15 and Resident #61) of eight residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #15 and Resident #61 rooms was in a position that was accessible to the residents. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #15 Review of Resident #15's Face Sheet, dated 05/15/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unspecified lack of coordination, generalized muscle weakness, and joint disorder. Review of Resident #15's Quarterly MDS Assessment, dated 02/26/2024, reflected Resident #15 had a severe impairment in cognition with a BIMS score of 00. Resident #15 required extensive assistance for bed mobility, eating and toilet use. Review of Resident #15's Comprehensive Care Plan, dated 02/27/2024, reflected Resident #15 was at risk for falling related to weakness and one of the interventions was to keep the call lights in reach at all times. Review of Resident #15's Progress Notes on 05/15/2024 denoted Resident #15 had a fall on 02/15/2024. Observation and interview with Resident #15 on 05/15/2024 at 9:54 AM revealed Resident #15 was on her bed awake. Resident #15's call light was noted on the floor and under the bed of the resident. Resident #15 tried to search for her call light but was not able to find it. Resident #15 stated she cannot even find the cord of the call light to pull it. She said the staff should put her call light where she could reach it because it was hard for her to move. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CNA E on 05/15/2024 at 9:55 AM, CNA E stated she did incontinent care to Resident #15 but did not notice that the call light was on the floor. CNA E said she did not make sure the call light was with the resident when she left the resident's room. CNA E picked up the call light from the floor, cleaned it and placed the call light across the resident's chest. She said the call light must always within the reach of the residents because they use the call lights to call the staff in cases of emergencies. CNA E added that if the call lights were not with the residents, the residents might fall or the staff will not know the residents were having an emergency. She said she was responsible in ensuring the call lights were within reach for her assigned residents. Resident #61 Review of Resident #61's Face Sheet, dated 05/16/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (insufficient oxygen in the brain causing stroke) affecting left non- dominant side, lack of coordination, and disorder of the muscles. Review of Resident #61's Quarterly MDS Assessment, dated 14/20/2024, reflected Resident #61 had a severe cognitive impairment with a BIMS score of 06. Resident #61 required extensive assist for bed mobility, transfer, and toilet use. Review of Resident #61's Comprehensive Care Plan, dated 04/23/2024, reflected Resident #61 was at risk of falling related to weakness and one of the interventions was to keep call light in reach at all times. Observation and interview with Resident #61 on 05/14/24 at 10:40 AM revealed resident was lying in bed. Wheelchair was next to end of his bed, bed on low position, call light not in reach and was on the floor in between the head of the bed and the nightstand. Interview with resident revealed he was experiencing a severe cramp in his leg and stated he could not reach or find call light. Resident #61 stated if the call light wasn't in reach he wasn't able to get help. Observation and interview with CNA F on 05/14/24 at 10:45 AM, CNA F stated that call light should be within reach of resident and risk to the resident would be he could not get help when he needed it. CNA F picked up the call light and put it next to the resident on his bed. In an interview with LVN G on 05/14/2024 at 10:45 AM, LVN G entered room and stated the call light was on the floor and stated call light should be clipped next to resident. LVN G said it was important the call light to be in reach, so resident can be helped when needed. In an interview with RN A on 05/16/2024 at 7:43 AM, RN A stated the call light should be within the reach of the residents at all times. RN A said for some residents, the call light was their sense of protection. She added the call light gave them the perception that when they needed something or was having an emergency, they could call the staff for help. RN A said the residents fall trying to get up and trying to get what they needed. RN A further said, aside from fall, the residents could suffer from injury and might be mad. RN A said everybody was responsible in making sure the call lights were with the residents, whether the resident was independent or not. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADON on 05/16/2024 at 7:21 AM, the ADON stated the call lights should not be on the floor or in a place where the residents could not reach it. The ADON said the call light must be within reach of the residents at all times because the call light was their method of communication. He said if the call lights were far from the residents, the residents would not be able to call the staff and their needs would not be addressed. The ADON said the expectation was for the staff to make sure the call lights were within the reach of all the residents and the call lights be placed on top of the bed when the residents were up. In an interview with the DON on 05/16/2024 at 7:35 AM, the DON stated the call lights were inside the residents' rooms for a reason. She added the residents used the call lights to call for assistance, for a glass of water, for a pain medication, or for incontinent care. The DON added without the call lights, the residents would not be able to tell the staff what they needed. The DON further added when the call lights were not within the reach of the residents, unfavorable incidents like falls, minor hurts, or major injuries could happen. The DON said the expectation was for the staff to ensure that the call lights were within reach of the residents at all times. The DON concluded that moving forward, she would be on top of this issue to make sure the staff would check always that the call lights were with the residents at all times. In an interview with Administrator on 05/16/2024 at 8:34 AM, the Administrator stated the call lights should not be far from the residents. The Administrator said the call lights were used by the residents to call the attention of the staff. The Administrator said the residents might need the staff for basic needs or in an emergency. He said the staff should be cognizant about call light placement. The Administrator said they would re-educate the staff regarding call lights and would monitor for three weeks if the in-service was effective. Record review of facility's policy Call Lights - Answering Of, Nursing Policies and Procedures, complete revision: 07/01/2016, revealed Policy: The staff will provide an environment that helps meet the patient/resident's needs . Procedure . 7. When leaving the room, be sure the call light is placed within the patient/resident's reach.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49427 Based on observations, interviews, and record review, the facility failed to consider the views of the resident group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility for three (05/9/2024, 04/11/2024, and 03/07/2024) of three Resident Council meetings reviewed for resident group response. The facility failed to ensure prompt efforts were made by the facility to resolve grievances of the confidential Resident Council reviewed for grievances. This failure could place facility residents at risk unresolved grievances, a decreased sense of self-worth, and a decline in quality of life. Findings included: Record review of Resident Council minutes dated 05/9/2024 reflected residents had concerns wanting more fruit and desert choices, and a monthly menu chat with person responsible noted as Dietary MGT and signed by Activity Director (AD). Review of Resident Council minutes dated 04/11/2024 revealed residents had concerns with wanting more fruit and desert choices, and a monthly menu chat with person responsible as Dietary MGT and signed by AD. Review of Resident Council minutes dated 03/07/2024 revealed residents had requested a menu chat monthly and were requesting more desert choices such as pies, cake choices, or brownies and No frosting on cakes!? The Activity Director would report issue to the Administrator and Dietary Management and the person responsible was the Administrator and Dietary Management, signed by AD. Record review of Grievance logs for the month of March 2024, April 2024, and May 2024 revealed no grievance filed on behalf of the Resident Council. Confidential group interview on 05/15/2024 revealed Resident Council had repeatedly brought up concerns that the food and dessert menu were repetitive and stated it was brought up as a concern at all of the past 3 months of Resident Council meetings. The group stated that the food was too repetitive and not appetizing because it was the same thing every week and the deserts had no variety and the cake frequently did not have frosting. The group stated that the AD was present and took notes at every Resident Council meeting and had told them he would speak with the Administrator and Dietary Manager, but they had not had a response after the March 2024, April 2024, or May 2024 meetings. The group stated that the AD suggested a monthly meeting between the Dietary staff and the Resident Council but it had not been scheduled. Observation on 05/14/2024 at 10:56 AM during kitchen inspection of the lunch menu for 05/15/2024 was hamburger on bun, seasoned French fries, ketchup, lettuce tomato, onion, pickles, frosted yellow cake, beverage of choice, and ice water. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/15/2024 at 11:45 AM with the AD revealed he started working for the facility at the end of November 2023 and attended all Resident Council meetings. AD stated he always attended and took notes and had brought up concerns at the morning meeting following Resident Council. AD stated in March 2024 he brought up the concern and the Administrator asked that the Dietary Manager talk to the Dietician about the resident's concern about variety. The AD stated at the April 2024 meeting the Resident Council brought up the exact same food concerns and he voiced their concerns during the morning meeting and the Administrator instructed him and Dietary Manager to get together and discuss the concerns with Resident Council. The AD stated at the May 2024 meeting, the Resident Council brought up the same food concerns and he brought up the concern during morning meeting and currently did not have anything scheduled for a visit with the Dietary Manager and the Resident Council. The AD stated that he did not file the Resident Council food concerns as a grievance because he did not think of their concerns to warrant the level of being filed as a grievance until now. He had been in contact with the Administrator and the Dietary Manager about the concern and they were aware. The AD stated that a meeting between the Dietary Manager and the Resident Council would be beneficial because it showed that the Resident Council concerns, were heard and there were resolutions. The AD stated that acting promptly and addressing concerns brought up in the Resident Council meeting was important so that residents felt dignity and respect and it was a resident right. The AD stated that the residents enjoying their food was important because it was something that they got to look forward to, it impacted their quality of life. Observation on 05/15/2024 at 12:55 PM revealed the test lunch tray for regular and puree diet had hamburger, with fries, lettuce, tomato, onion, and pickle on the side, yellow cake that did not appear to be frosted. In an interview on 05/15/2024 at 12:56 PM with the Dietary Manager, she stated she did not receive any feedback from the Resident Council regarding food concerns since the mock survey in January. She stated that if the Resident Council had concerns about food then the Activity Director was supposed to draft a grievance which would generate a notification to her based on their feedback. She had not received any notices from the past 3 Resident Council meetings. In an interview on 05/17/2024 at 11:52 AM with the Administrator revealed the facility has a set menu and recalled that Resident Council had voiced concerns regarding the menu receptiveness and deserts options at the March, April, and May meetings at morning meeting by the Activity Director. He stated that the facility had a mock survey in February of 2024 and the residents' concerns about the food were brought up and it was recommended that they set up a meeting time with the dietary staff and the Resident Council. He expected the Dietary Manager and the Activity Director to connect and make time to address the concern and meet with the Resident Council, but it had not happened yet. The Administrator stated he did not follow up about the food concerns because it did not come up to the level of a grievance, they were more like personal preferences. The Administrator stated that if a resident had weight loss or were refusing their meals because they were inedible then that situation would call for a grievance. The Administrator stated that the purpose of the Resident Council was to get feedback on certain topics and monitor for any major grievances and advocate for themselves and other residents. Administrator stated that resident council did not receiving responses to their concerns could make residents feel like their voice did not matter. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/17/24 at 12:26 PM with the Regional Dietician revealed that if the menu says frosted cake, then the food should have frosting that was visible. She said they should follow what the resident preferences were because it impacted their quality of life and was one of the few things they can have a say in. Review of recipe titled Frosted Yellow Cake revealed the following instructions for frosting: 7. Combine creamed margarine, sugar, and milk. Mix well. Add melted chocolate and vanilla. Beat until fluffy. Review of facility's Resident Council policy titled Social Services Policies and Procedures dated revised 06/09/2023 revealed The Procedures . 8. The Resident Council or Group can voice group recommendations. 9. The Activities Director will attempt to follow-up on and provide feedback on the Council's/Group's concerns and recommendations.

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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** 37028 Based on observations, interviews, and record review, the facility failed to ensure the care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for one (Resident #70) of eight residents reviewed for care plan. The facility failed to ensure Resident #70's care plan was revised to reflect person centered interventions for hydration. This failure could place the resident at risk of current needs not being met. Findings included: Review of Resident #70's MDS assessment dated [DATE], reflected that the resident was a [AGE] year-old male admitted on [DATE]. His cognition was severely impaired. Relevant diagnoses included Alzheimer's disease, malnutrition, dysphagia (difficulty swallowing), and Down Syndrome. The resident was dependent on staff for oral care and nutrition. Review of Resident #70's Comprehensive Care Plan dated 01/16/24 reflected: Resident at risk for dehydration Interventions included: keep fluids available An observation on 05/15/24 at 12:50 PM revealed Resident #70 was unable to drink fluids independently. CNA U was administering nectar-thickened liquids to the resident. The resident was non-verbal. Resident #70 drank approximately 120 cc thickened water. CNA U also had to feed the resident his meal. The resident ate 75% of meal. An interview on 5/16/24 at 10:25 AM with the DON and the ADON revealed the care plan was not appropriate for Resident #70 because he was not able to drink fluids by himself. The DON said she would need to make a more specific care plan for the resident. Record review of facility policy, Social Services Policies and Procedures, dated 10/02/20, reflected: Subject: Person-Centered Care Plan Policy: The resident has the right to be informed of and participate in treatment and the right to participate in the development and implementation of a person-centered plan of care.

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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** 37028 Based on observations, interviews, and record review, the facility failed to provide the necessary services to maintain good oral hygiene to a resident who was unable to carry out activities of daily living for one of eight residents (Resident #70) reviewed for ADL care. The facility failed to provide Resident #70, who required extensive assistance, with timely oral care and sufficient fluids to keep the resident's mouth moist. This failure could place residents at risk of oral hygiene problems including dry mouth, cavities, and infection. Findings included: Review of Resident #70's MDS assessment dated [DATE], reflected that the resident was a [AGE] year-old male admitted on [DATE]. His cognition was severely impaired. Relevant diagnoses included Alzheimer's disease, malnutrition, dysphagia (difficulty swallowing), and Down Syndrome. The resident was dependent on staff for oral care and nutrition. Review of Resident #70's Comprehensive Care Plan dated 01/16/24 reflected: Resident at risk for dehydration Interventions included: keep fluids available. There was not a care plan for oral care . An observation on 05/15/24 at 11:24 AM revealed Resident #40 was lying in bed. He was awake and alert. His lips were dry and cracked. His teeth were covered in a paste-like substance. He had thick oral secretions and was breathing through his mouth. CNA U was at the bedside and said the resident required assistance with all care. CNA U said she gave the resident fluids with breakfast. CNA U pointed to a cup with approximately 60cc of thickened water missing from the 8-ounce cup. CNA U said it was important for the resident to receive sufficient fluids . An observation on 05/15/24 at 12:50 PM of Resident #70 and CNA U revealed the resident drank approximately 120 cc thickened water. An observation and interview on 5/16/24 at 10:25 AM with the DON and the ADON revealed Resident #70 was lying in bed. There was a paste-like substance on his teeth and lips. His lips were dry and cracked. The DON said the denture paste caused the resident's mouth to look dry and cracked. The DON said oral care was supposed to be performed every shift, but that the resident needed oral care at that time. The DON said the resident needed oral care very often and that there was not a care plan for it. The DON said it was important for the resident to receive frequent oral care because it could cause infection and she would need to make him a specific care plan for oral care to ensure it was performed often. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy, Hydration-Oral, not dated, reflected: .4. Patients/Residents with swallowing disorders are offered thickened liquids in the proper consistency under the direction of qualified clinical staff. Orders are obtained to provide hydration at specified intervals, for example offering of thickened with each medication pass and between meals. This is documented in the care plan. Record revoew of the facility policy, Activities of Daily Living, Optimal Function, revised 2017, reflected: Policy .The Facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygeine.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that Residents, who needed respiratory care, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for four (Resident #29, Resident #61, Resident #66, and Resident #71) of ten residents reviewed for respiratory care. 1. The facility failed to ensure Resident #29's nasal cannula was changed weekly and was properly stored. 2. The facility failed to ensure Resident #61's nasal cannula was properly stored. 3. The facility failed to ensure Resident #66's nasal cannula was properly stored. 4. The facility failed to ensure Resident #71's breathing mask for nebulization was changed weekly and properly stored. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Review of Resident #29's Face Sheet, dated 05/15/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic respiratory failure with hypoxia (insufficient amount of oxygen in the body) and shortness of breath. Review of Resident #29's Comprehensive MDS Assessment, dated 04/17/2024, reflected resident had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment also indicated resident was on oxygen therapy. Review of Resident #29's Care Plan, dated 05/08/2024, reflected resident required oxygen therapy 2 - 3 liters per minute related to asthma and respiratory failure and one of the interventions was to administer oxygen as ordered. Review of Resident 29's Physician Order, dated 03/03/2024, reflected, O2 at __2__ liters per minute via nasal cannula. Review of Resident 29's Physician Order, dated 03/03/2024, reflected EQUIPMENT: Keep O2 cannula/mask/tubing and/or Nebulizer mask/tubing bagged when not in use. Review of Resident 29's Physician Order, dated 03/03/2024, reflected EQUIPMENT Oxygen: Change O2 tubing/nasal cannula/mask/humidification system weekly. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/14/2024 at 9:37 AM revealed Resident #29 was on her bed with oxygen at 2 liters per minute via nasal cannula. It was also noted that the resident had an oxygen tank at the back of her wheelchair with a nasal cannula connected to it. The prongs of the nasal cannula were observed on the seat of the wheelchair. It was not bagged. it was also noted that the nasal cannula was dated 04/25/2024. Observation and interview with CNA C on 05/14/2024 at 9:37 AM revealed CNA C was about to transfer Resident #29 from bed to wheelchair. CNA C positioned the wheelchair parallel to the end of the resident's bed. CNA C said she was the one who put the nasal cannula on the seat of the wheelchair. When CNA C further positioned the wheelchair, the nasal cannula fell on the floor. Interview and observation with LVN B on 05/14/2024 at 9:43 AM, LVN B stated the nasal cannula should not be on the floor or placed on the wheelchair when not in use. He said it should be bagged to prevent contamination and infection. LVN B picked up the nasal cannula that was on the floor and disconnected it from the oxygen tank and said he would change it. LVN B then saw the date of the nasal cannula which was 04/25/2024. He said the nasal cannula should be changed weekly to make sure there was no growth of microorganisms in the tubing. LVN B left the room and came back with a new nasal cannula and connected it to the oxygen tank behind Resident #29's wheelchair. 2. Review of Resident #61's Face Sheet, dated 05/16/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. One of the relevant diagnoses was wheezing. Review of Resident #61's Quarterly MDS Assessment, dated 14/20/2024, reflected Resident #61 had a severe cognitive impairment with a BIMS score of 06. Resident #61 required extensive assist for bed mobility, transfer, and toilet use. Review of Resident #61's Comprehensive Care Plan, dated 04/23/2024, reflected resident was at risk for SOB and one of the interventions was to administer oxygen as ordered. Review of Resident #61's Physician Order, dated 05/14/2024, reflected O2 at __2-3__ liters per minute via nasal cannula PRN for SOB. Review of Resident 61's Physician Order, dated 03/10/2023, reflected EQUIPMENT: Keep O2 cannula/mask/tubing and/or Nebulizer mask/tubing bagged when not in us. Observation on 05/14/24 at 10:40 AM revealed Resident #61was lying in bed. It was noted that the resident's nasal cannula was not bagged and was lying coiled on the floor in between the oxygen machine and the nightstand. Observation and interview with LVN G on 05/14/2024 at 10:45 AM, LVN G entered the room and stated the nasal cannula should be bagged and off the floor. LVN G disconnected the nasal cannula from the oxygen concentrator and said she would change it. 3. Review of Resident #66's Face Sheet, dated 05/15/2024, reflected that resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included acute chronic respiratory failure with hypoxia and shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #66's Quarterly MDS Assessment, dated 04/30/2024, reflected that Resident #66 had an intact cognition with a BIMS score of 15. The Quarterly MDS also indicated that the resident was on oxygen therapy while a resident of the facility. Review of Resident #66's Comprehensive Care Plan, dated 05/08/2024, reflected resident required oxygen therapy related to respiratory failure and SOB and one of the interventions was administer oxygen as order. Review of Resident #66's Physician Order, dated 04/26/2024, revealed O2 at 3 liters per minute via nasal cannula. Observation and interview with Resident #66 on 05/14/2024 at 11:46 AM revealed the resident was on his wheelchair inside the room. It was noted resident had an oxygen concentrator at bedside. A nasal cannula was connected to the oxygen concentrator and was hanging on top of the concentrator. Resident #66 also had an oxygen tank behind his wheelchair with a nasal cannula connected to it. The cord of the nasal cannula was coiled around the oxygen tank with the prongs of the nasal cannula touching the top of the oxygen tank. Both nasal cannulas were not bagged. According to the resident, he was on oxygen since he came back from the hospital. He said he never saw a bag for his nasal cannula, nor has anyone told him to put the nasal cannula in a bag. 4. Review of Resident #71's Face Sheet, dated 05/15/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. One of the relevant diagnoses included acute respiratory failure with hypoxia. Review of Resident #71's Quarterly MDS Assessment, dated 04/24/2024, reflected that Resident #71 had a severe impairment in cognition with a BIMS score of 00. Review of Resident #71's Comprehensive Care Plan, dated 04/25/2024, reflected that Resident #71 was at risk for respiratory failure and one of the interventions was administer medications as ordered. Review of Resident #71's Physician's Order, dated 04/25/2024, reflected, Pharmacy Dispensed Drug: Ipratropium-Albuterol 0.5-2.5 (3) MG/3ML Solution Pharmacy Directions: 1 VIAL VIA NEBULIZER EVERY FOUR HOURS AS NEEDED. Observation and interview with Resident #71 on 05/14/2024 at 11:24 AM revealed the resident was on her bed, awake. It was also noted that her breathing mask used for the nebulizer was inside the drawer. The breathing mask was not bagged. According to the resident, she had breathing treatment every morning. She said the nurse would be the one to put it on and the one who took it off. It was noted the breathing mask was dated 04/25/2024. Interview and observation on 05/14/2024 at 12:17 PM, LVN B stated he administered Resident #71's breathing treatment. LVN B opened the resident's side table drawer and acknowledged he was not able to put the breathing mask inside the bag after the resident's breathing treatment was done. He said the breathing mask should also be bagged just like the nasal cannula to prevent infection. He said he would change the breathing mask and would put it in a bag. He said he did not notice that Resident #66's nasal cannula was on the oxygen concentrator and behind the wheelchair not bagged. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the ADON on 05/16/2024 at 7:21 AM, the ADON stated the breathing mask, and the nasal cannula should be bagged when not in use. The ADON said it was the proper way to store the breathing mask and the nasal cannula. He said if those breathing apparatuses were not bagged, exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The ADON also said the nasal cannula and the breathing mask should be changed weekly. He said the staff, including him, were responsible for monitoring that the apparatus used in oxygen therapy were bagged when not in use and changed weekly. He said he would in-service regarding proper storage and changing of the nasal cannula and breathing mask. In an interview with the DON on 05/16/2024 at 7:35 AM, the DON stated the nasal cannula, and the nebulizer should be bagged when not in use. She said there should be an available bag on the drawer of the resident where the nurse could put the breathing mask after every breathing treatment. She added there should also be an available plastic bag on the concentrator where the staff could put the nasal cannula when not in use. She said the nasal cannula at the back of the wheelchair should also be bagged when the resident was not using it. The DON explained the nasal cannula should not be touching the seat of the wheelchair, the sides of the concentrator, or the oxygen tank because it could cause contamination that could lead to respiratory infection. She also said the nasal cannula should be changed every week to make sure there prevent accumulation of microorganism that could compromise the respiratory system. She said everybody was responsible for checking if the nasal cannula and the breathing mask were changed or bagged. She said the expectation was the breathing mask and the nasal cannula would be stored properly. The DON concluded she would continually remind the staff to be diligent in making sure the procedures for respiratory care were followed. In an interview with the Administrator on 05/16/2024 at 8:34 AM, the Administrator stated the breathing masks, and the nasal cannulas should be stored properly to prevent potential respiratory infections. He added the nasal cannula, and the breathing mask should be changed weekly as per doctor's order. He said the staff should be cognizant about proper storage of the nasal cannula and the breathing mask, as well as when to change them. The Administrator said they would re-educate the staff regarding the issue and would monitor for three weeks if the in-service was effective. Record review of facility's policy, EQUIPMENT CHANGE SCHEDULE, RESPIRATORY POLICIES AND PROCEDURES revised 2/1/2020 revealed Policy: The Facility shall have a schedule for changing disposable equipment . Procedure: Equipment will be changed as follows: . tubing and aerosol nebulizer . Every week . place in clean, dry plastic bag . write date change in tubing.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 49427 Based on observations, interviews, and record review, the facility failed to ensure that pain management was provided for 2 (Resident#4 and Resident #36) of 8 residents reviewed for pain. 1. The facility failed to provide effective pain management for Resident #36 after she experienced a fall on 05/09/2024 she was observed by staff resulting in signs of pain such as grimancing and screaming with movement. 2. The facility failed to provide effective pain management for Resident #4 when his pain medication was reduced without his knowledge resulting in him experiencing unnecessary pain and suffering and psychosocial harm. On 05/16/2024 at 4:51 PM an immediate jeopardy was identified. While the IJ was removed on 05/17/2024 at 11:21 AM the facility remained out of compliance at a scope of pattern with a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and the effectiveness of their Plan of Removal. These failures placed residents at risk for prolonged and unnecessary pain and suffering and a decreased quality of life. Findings included: 1. Review of Resident #36's Quarterly MDS dated [DATE] reflected she was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's disease (loss of cognition), stroke, depression (low mood), muscles weakness, unspecified lack of coordination, abnormal position, neurocognitive disorder with Lewy bodies (abnormal deposits of protein in brain leading to loss of cognition, balance, alertness), and a BIMS score of 3 (severe cognitive impairment). Review of Resident #36's Care Plan reflected problem start date of 03/30/2022 that the resident had difficulty making self-understood and had unclear speech. Review of care plan reflected problem start date of 03/10/2022 that the resident was at risk of complaints of chronic pain and used narcotic pain medication due to disease process with approaches of: monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors . monitor and record any non-verbal signs of pain, complaints of pain, and evaluate effectiveness of pain management interventions. Record review of Resident #36's Physical Therapy Treatment Encounter Notes with date of service of 05/06/2024, signed by PTA CC 05/06/2024 at 11:08 AM revealed the resident showed no signs of pain, was treated in the gym and showed no signs of pain. The summary of skilled services included gait training, bilateral lower extremity exercises focused on progressive resistive exercise and bike exercises to enhance muscle strength. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #36's Occupational Therapy Treatment Encounter Notes with date of service of 05/06/2024, signed by OT BB 05/06/2024 at 6:29 PM revealed Resident #36 showed no signs of pain. Review of Resident #36's resident progress notes dated 05/09/2024 by LVN N revealed the resident had a witnessed fall on 05/09/2024 around 5:45 AM when the resident was observed in the hallway wobbling and then fell sliding into the ground on her right knee. The resident was provided a head-to-toe assessment, neuro checks were started, and the resident could not say why she was out of bed. The only injury noted was to her right knee, it was slightly red and sore. LVN N noted that the resident was put to bed. The resident was noted to have dementia and did not know why she was up. Review of Resident #36's progress notes for 05/09/2024 by LVN N at 1:43 AM revealed the resident continued on neuro checks for fall, no delayed injury noted. Right slightly red no swelling noted and resident was reminded to use walker and with supervision. Review of Resident #36's progress notes for 05/09/2024 by LVN P at 11:19 AM revealed Resident #36 had no delayed injuries due to pain and denied any pain or discomfort. Review of Resident #36's progress notes for 05/09/2024 by RN H at 4:33 PM revealed Resident #36 had no post fall injuries and the resident denied pain. Record review of Resident #36's Occupational Therapy Treatment Encounter Notes with date of service of 05/09/2024, signed by OT BB 05/09/2024 at 6:15 PM, revealed resident showed signs of pain that included grimacing, protective behaviors to areas of pain, limited resident ability to sit up at the edge of the bed and transfers, pain was relieved by sitting still and exacerbated with prolonged activity, and resident had a fall on the morning of 05/09/2024 and complained of pain to her lower right extremity. Review of Resident #36's progress notes for 05/09/2024 by RN H at 9:39 PM revealed Resident#36 was noted moaning, holding her right leg any time she is given incontinent care. Resident assessed. Right hip to ankle painful to touch, no redness no swelling noted. Tramadol 50mg tab routine admin [sic]. NP notified no new order received. Review of Resident #36's progress notes for 05/10/2024 by LVN N at 5:54 AM revealed there was an incident with Resident #36 and her roommate, and the resident was assessed head to toe, was asleep, had no discoloration or any injuries, denied any pain, and was moved to a different room. Review of Resident #36's progress notes dated 05/10/2024 by MDS LVN between 11:33-11:45 AM revealed a cognitive assessment of Resident #36 was completed and revealed that the resident was able to repeat 2 words, was unable to recall the correct year, month, or day of the week, resident speech was unclear, and resident stated that occasional pain, rarely disturb for sleep, activity, therapy activity, pain scale 7. Will continue to monitor. Review of Resident #36's progress notes dated 05/10/2024 at 12:49 PM by LVN Q revealed resident had no delayed injury, no neuro deficits. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #36's progress notes dated 05/10/2024 at 8:46 PM by RN H revealed Resident #36 had continued neuro checks for fall, no post fall injury noted or reported, resident denied pain, and care was given as needed by staff. Review of Resident #36's progress notes dated 05/11/2024 at 2:38 AM by LVN N revealed Resident #36 needed assistance with all activity of daily living, had neuro checks due to fall, and was adjusting to room change. Review of Resident #36's progress notes dated 05/12/2024 at 7:34 PM by LVN R revealed Resident #36 was post fall and noted grimacing in pain during ADL's. Notified NP [Nurse Practitioner DD]. No new orders. Review of Resident #36's progress notes dated 05/12/2024 at 8:40 AM by LVN S revealed the Nurse Practitioner DD for Physician K was notified and a new order was received for an x-ray because Resident #36 was observed in therapy with a nurse aide screaming by holding her right hip. The pain increase [sic] when patient moves her right leg, turn to left side, and during care. Tylenol 500 mg for pain given. Record review of Resident #36's Physical Therapy Treatment Encounter Notes with date of service of 05/13/2024, signed by Physical Therapist GG 05/13/2024 at 3:40 PM revealed resident consistently stated increased pain on the right lower extremity at the start of therapy session and was unable to complete bed mobility exercises due to increased pain and nursing was notified. Record review of Resident #36's Occupational Therapy Treatment Encounter Notes with date of service of 05/13/2024, signed by OT BB 05/13/2024 at 6:24 PM revealed the resident showed signs of pain to her lower right extremity that included reflexive behaviors such as saying ouch, stop, protecting, moaning, holding area of pain, limited resident ability to sit up for meals, and pain was relieved by remaining still and exacerbated with sitting and prolonged activity. OT BB noted that resident complained of severe pain with movement to lower right extremity and that Director of Rehabilitation reported the resident had an x-ray of the knee with negative results and a hip x-ray was recommended to be done. Record review of Resident #36's Physical Therapy Treatment Encounter Notes with date of service of 05/14/2024, signed by PTA CC 05/14/2024 at 11:35 AM revealed the resident had increased pain on both sides of her lower extremities and nurse was aware and arranging for an x-ray series for bilateral hip assessment. Review of Resident #36's orders revealed there was a prescription for pain medication Tramadol 50 mg, one tablet, by mouth, twice a day for unspecified pain with a start date of 11/17/2022 through 05/15/2024 and an order for 500 mg of Tylenol, PRN (as needed) with a start date of 11/17/2022 through 05/15/2024 . Review of Resident #36's Medication Administration Report (MAR) for 05/01/2024 through 05/19/2024 revealed the resident had a PRN (as needed) order for Tylenol 500mg and was not given any PRN doses after her fall on 05/09/2024 until 05/14/2024 at 8:38 AM by LVN S for pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #36's Medication Administration Report (MAR) for 05/01/2024 through 05/19/2024 revealed the resident had a PRN (as needed) order for Ibuprofen 200mg with a start date of 11/17/2022 and was not given any PRN doses after her fall on 05/09/2024. Review of Resident #36's MAR for 05/01/2024 through 05/19/2024 revealed resident was given Tramadol 50 mg, one tablet, by mouth twice a day for unspecified pain at 9:00 AM and 8:00 PM from 05/01/2024 through 05/15/2024. Review of MAR revealed Resident #36 order was changed to Tramadol 50 mg, one tablet, by mouth, 3 times a day starting on 05/15/2024. Review of X-Ray report with date of service of 05/15/2024 for Resident #36 reflected there is a possible nondisplaced intertrochanteric fracture of the right femur of indeterminate age. Review of X-Ray report with date of service of 05/14/2024 for Resident #36 reflected resident had an x-ray of her left and right hip due to unspecified pain with the findings of a nondisplaced right intertrochanteric fracture of indeterminate age with clinical follow up recommended. Observation on 05/14/2024 at 2:16 PM revealed Resident #36 was lying in bed, hair appeared clean, and was wearing a hospital gown and had a blanket. Resident #36 asked to be cleaned and did not appear to know how to use the call button that was within reach. RN H was informed that the resident was in need of assistance and stated she would help the resident immediately. Observation and interview on 05/15/2024 at 3:05 PM revealed X-ray Technician waiting outside of Resident #36's room with a portable x-ray. He stated he was waiting for RN H to assist him because the last time the resident was screaming. Observation on 05/15/2024 at 3:13 PM the resident was heard from outside the room with the door closed saying ow. Interview on 05/15/2024 at 3:30 PM with RN H revealed that Resident #36 recently had a witnessed fall on 05/09/2024 and that she assessed resident the day of the fall and observed some redness to her knee and lower extremity was painful to touch, resident was put in bed and the Nurse Practitioner was notified with no new orders and family was notified. RN H stated that resident did not appear to be in pain when in bed. RN H stated on 05/10/2024, Resident #36 did not appear to be in pain when she was in bed or when asked but there were some signs of pain during activities of daily living care and the Nurse Practitioner was notified with no new orders. RN H stated the x-ray was ordered on 05/15/2024 because the resident was observed screaming and yelling out and grimacing during activity of daily living care. RN H stated it was appropriate to contact the Nurse Practitioner instead of Physician. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 05/16/2024 at 2:04 PM with DON revealed Resident #36 had a fall on 05/09/2024 and staff had told her that resident had some redness to her knee but was not complaining of pain and had good range of motion and thought she was fine, she was walking in the hall. DON stated that it was not uncommon for Resident #36 to complain of generalized pain and was not aware that staff and therapy were documenting that Resident #39 was showing symptoms of right hip pain after 05/09/2024 and that it would have been a change in condition for the resident. DON stated she had not read therapy's notes that noted resident was immobile and she did not have access to those notes. DON stated the Nurse Practitioner was notified of Resident #36's fall on 05/09/2024, were provided no new orders. DON stated that she was aware on 05/15/2024 that resident had hip pain so Dr. K was notified and ordered an x-ray. DON stated that the result of the x-ray was that resident had a hairline fracture and the plan was to not do surgery and to try to keep resident immobile as much as possible and manage pain. DON stated that staff are supposed to notify the physician but physicians direct staff to contact Nurse Practitioner if he was not available. DON stated that she had seen Resident #36 out of bed since her fall on 05/09/2024 and was not told of the symptoms of hip pain by staff. DON stated that Resident #36 was provided Tylenol for breakthrough pain. DON stated that nursing staff were responsible for monitoring, and notifying physician of resident pain if uncontrolled, and to document and provide pain medication given to residents and their pain levels. DON stated that not providing pain management for residents would impact their quality of life if their pain was not managed. DON stated that they always contacted NP EE for changes in condition. Interview on 05/16/2024 at 2:50 PM with Power of Attorney (POA) for Resident #36 revealed she was notified on 05/09/2024 that resident had fallen and did not have any pain. POA stated she was not notified about any symptoms or signs of pain for Resident #36 until 05/15/2024 when she was contacted by facility stating Resident #36 displayed signs of pain and an x-ray had been ordered. Interview on 05/16/2024 at 3:46 PM with Physician K revealed he was an attending physician at the facility and was notified that Resident #36 had a fall and was told she did not have pain. Physician K stated that he was at the facility on 05/14/2024 and a nurse practitioner informed him that the resident had pain, an x-ray was ordered, and resident had a nondisplaced fracture or a hairline fracture of her hip. Physician K stated he ordered a second x-ray to confirm the original findings because it would impact the treatment plan. Physician K stated that he expected if a resident had significant pain they would be sent to the emergency room . Physician K stated it was important for any new or different pain symptoms to be reported to the physician so he was aware of the resident's condition and able to make necessary orders. Physician K stated that staff not reporting resident with pain symptoms could result in a resident experiencing pain for extended periods of time or not receiving proper treatment. Interview on 05/17/2024 at 2:50 PM with Physician L revealed he was a pain management physician at facility and if a resident had a pain management concern physician facility staff might call them if resident was having pain but he was not aware that Resident #36 was experiencing pain after 05/09/2024 until 05/14/2024. Physician L stated that if he knew resident was experiencing pain after her fall on 05/09/2024 he would have ordered an x-ray sooner. Physician L stated he would expect staff to check for resident pain post fall by flexion and adduction and look for visual or verbal indications of pain such as grimacing or crying out. Physician L stated the risk to a resident by not notifying the physician about a change of condition of resident could result in a resident to not be provided care they needed or remain in pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 05/19/2024 at 11:30 AM of Resident #36 revealed she was lying in bed sleeping, wearing hospital gown, covered with a blanket with call light within reach and water cup at bedside table. Interview on 05/20/2024 at 1:00 PM with Nurse Practitioner (NP) EE revealed if a resident was already on pain management and they were experiencing pain, the staff would reach out to her. NP EE stated she was not aware that resident was having pain until 05/15/2024 when the nurses told her that the resident was in a lot of pain when she moved. NP EE stated that she doesn't like to give stronger medications than Tylenol 3 or Tramadol and was able to write prescriptions for those medications without asking the Physician AA. NP EE stated Resident #36 was on already on Tramadol 50 mg two times a day for generalized pain and increased frequency to 3 times a day and added Tylenol 650 mg three times a day starting 05/15/2024. NP EE stated she did not know who ordered the x-ray and did not remember asking Physician AA about Resident #36. NP EE stated that the risk to a resident when they do not receive proper pain management was that they could have decreased movement, increase of pain, and decrease in quality of life. 2. Review of Resident #4's Comprehensive MDS dated [DATE] revealed resident was an [AGE] year-old male, admitted on [DATE], with diagnoses of postlaminectomy syndrome (a condition that causes pain or other sensations in the body after spinal surgery), muscle weakness, unspecified abnormalities of gait and mobility, chronic pain syndrome (pain that can be continuous or may come and go and persists for weeks or years), anemia (low iron), hyponatremia (low salt levels), hyperlipidemia (elevated levels of fat in blood), arthritis (inflammation of the joints causing pain and stiffness), stroke (loss of blood flow to the brain), dementia (loss of cognition), depression (persistent low moods), asthma, macular degeneration (eye disease causing vision loss), and a BIMS score of 15 (intact cognition). Review of Comprehensive MDS revealed the care area of pain was triggered for pain. Review of Resident #4's Care Plan with problem start date of 03/25/2024 revealed Resident is at risk complaints of chronic pain, use routine pain meds and Narcotic PRN [as needed] R/T [due to] chronic pain syndrome, disease process. Review of Resident #4's face sheet dated 05/14/2024 revealed Resident #4 had a Resident Representative, and he was his own representative. Observation and interview on 05/14/2024 at 1:46 PM with Resident #4 revealed he was lying in bed with a slightly curled position and with a blanket wrapped over his neck and appeared stiff. He stated he does not get his oxycodone every 4 hours even though the Physician prescribed it. He stated the staff taunt him by saying he has 1 minute until he can have his next dose or 6 minutes and it made him feel really bad and he felt that he was having more breakthrough pain due to the delays. Resident #4 stated he had chronic pain due to previous surgeries, cervical (neck) fusion and lumbar (back) fusion. He stated some of the hardware caused him pain and that he took the same dosage for years with his orthopedic Physician and his pain was usually controlled enough at a level 2 or 4 when he took his medication regularly. Resident #4 stated that he was involved in his care planning and stated that the facility was aware that he had chronic pain syndrome and needed oxycodone every 4 hours. The facility said they can accommodate his need, but the order would have to be PRN. This means when needed, so you would need to ask for it every 4 hours if you needed the pain medication. Resident #4 stated that he understood that to mean he needs to ask every 4 hours, so he did. He stated it seemed like they did not understand his pain, that his pain will flare up if he misses the dose of oxycodone every 4 hours. (continued on next page)

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	676248	A. Building B. Wing	05/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Founders Plaza Nursing & Rehab	721 S Hwy 78 Wylie, TX 75098

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review Resident #4 orders revealed following orders: -Oxycodone, Schedule II, 15 mg, one tablet, by mouth, every 4 hours with a start date of 04/29/2024 and end date of 05/01/2024. -Oxycodone, Schedule II, 15 mg, one tablet, by mouth, every 4 hours PRN (as needed) with a start date of 05/01/2024 and end date of 05/02/2024. -Oxycodone, Schedule II, 10 mg, one tablet, by mouth, every 4 hours PRN (as needed) with a start date of 05/02/2024 and end date of 05/02/2024. -Oxycodone, Schedule II, 15 mg, one tablet, by mouth, every 4 hours PRN (as needed) with a start date of 05/18/2024. -Buprenorphine Schedule III patch, 10mcg/hour one transdermal film every 7 days for chronic pain with a start date of 04/30/2024 and end date of 05/03/2024 and another start date of 05/03/2024 with end date of 05/17/2024. Review of Resident orders with a start date of 05/18/2024 for Resident #4 for psychology evaluation for possible drug seeking behavior and decreased perception of pain. Review of Resident #4 orders Medication Administration History for 05/01/2024 through 05/18/2024 revealed resident received Oxycodone, 10 mg for pain on: 05/01/2024: none 05/02/2024 at: -6:18 PM by LVN M 05/03/2024 at: -6:41 PM by LVN M 05/04/2024 at : -12:17 PM by LVN T -4:15 PM by LVN M 05/05/2024 at: -6:52 AM by LVN P -11:23 AM by LVN P -4:07 PM by LVN P (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Founders Plaza Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 721 S Hwy 78 Wylie, TX 75098	

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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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-8:17 PM by LVN P 05/06/2024: -7:23 AM by LVN G -11:37 AM by LVN G -3:41 PM by RN I -7:40 PM by RN I 05/07/2024: -5:59 AM by LVN O -10:05 AM LVN G -7:32 PM by RN I 05/08/2024: -5:06 AM by LVN T -9:10 AM by LVN G -4:16 PM by RN I -8:18 by RN I 05/09/2024: -9:13 AM by LVN G -3:15 PM by RN I -7:15 PM by RN I 05/10/2024: -8:47 AM by LVN G -5:02 PM by LVN V 05/11/2024: -1:56 PM by LVN V (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	05/12/2024: -7:00 AM by LVN P -11:54 AM by LVN V -3:55 PM by LVN P -8:04 PM by LVN P 05/13/2024: -4:30 AM by LVN X -8:37 AM by LVN G -4:38 PM by RN I -9:05 PM by RN I 05/14/2024: -5:05 AM by LVN T -5:06 PM by RN I -9:09 PM by RN I 05/15/2024: -5:02 AM by LVN T -11:55 AM by LVN G -4:20 PM by RN I -8:21 PM by RN I 05/16/2024: -2:50 AM by LVN O -8:04 by LVN G -3:41 PM by RN I -7:50 PM by RN I (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	05/17/2024: -8:40 AM by LVN G -12:34 PM by LVN G -5:43 PM by LVN V -9:35 PM by LVN V 05/18/2024: -4:39 AM by LVN O -8:46 AM by LVN P Review of Resident #4 orders Medication Administration History for 05/01/2024 through 05/18/2024 revealed resident received Oxycodone, 15 mg for pain on: 05/18/2024 at 9:09 PM by LVN P 05/19/2024 at 10:11 AM by LVN P Review of Resident #4's nurse's progress notes revealed note dated 04/27/204 by LVN N at 11:56 PM . resident continue on excessive amount of pain med gets it every 4 hours around clock prn [as needed] will contact pain doctor to reevaluate him. Review of Resident #4's nurse's progress notes revealed note dated 04/28/204 by LVN N at 5:50 AM Resident continues on skill charting appears obsessed [sic] with pain med demanding it every 4hr around the clock does not seem to be in pain when checking [sic] on resident always sleeping. Review of Resident #4's nurse's progress notes revealed note dated 04/29/204 at 1:26 AM by LVN N . Appears to be taking to [sic] many pain pills will have day shift get in touch with dr. Review of Resident #4's progress notes revealed note dated 04/29/2024 at 12:20 PM by LVN M As per DON, Oxycodone 15mg changed to schedule Q4hr as Pt continues to request for Pain medication every 4 hrs. Review of Resident #4's progress notes revealed note dated 05/02/2024 at 1:01 AM by LVN N Residents oxycodone 15 changed to 10mg q 4hr prn but was put on pain patch 10mg. Review of Resident #4's progress notes revealed note dated 05/03/2024 at 8:29 AM by LVN M Resident continues on pain mgt with oxycodone 10mg PRN Q4hrs, no discomfort reported at this time, plan of care on-going. Review of Resident #4's progress notes revealed note dated 05/07/2024 at 8:35 AM by LVN G Resident refused to take morning medication when he was offered. Resident wants CMA to wait until later. Medication will be offered in a later time. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #4's progress notes revealed note dated 05/08/2024 at 2:16 PM by LVN G Resident refused patches to be placed. Review of Resident #4's progress notes revealed note dated 05/10/2024 at 1:32 PM by LVN G: Resident continues to refuse pain patches. Resident also using Icy Hot cream topically for pain. No order in place. Notified pain NP to obtain order, no order needed for the icy hot, per NP. NP wants resident to be encouraged to use pain patches. NP will be in the facility and will see resident. Review of Resident #4's progress notes revealed note dated 05/15/2024 at 10:43 AM by LVN G: Resident refused pain patches and buprenorphine patch. Resident states I don't want them. I have to talk to my Dr. That is too much chemicals for my heart. This nurse explained to the resident that buprenorphine patch is for pain and he gets it once a week but resident refused stating that he gets oxycodone and does not need that patch. Pain management NP notified. WCTM. Review of Resident #4's progress notes revealed note dated 05/15/2024 at 1:14 PM by LVN G NP called back about resident's refusal of pain patches. Will talk to resident when in facility. Interview on 05/15/2024 at 2:06 PM with Resident #4 revealed he was told by a nurse that he had been prescribed a patch for pain and was concerned about the interactions between that patch and his current pain medication since he had heart problems in the past and bad experiences with patches. Resident #4 stated that he said he told the nurse that he wanted to talk to his Physician about the concern. He stated his previous Physician, he was with for [AGE] years, and felt that he had figured out a pain management schedule that already had been working for him. Resident #4 stated that the staff told him that this was how it was, you talk with the nurse practitioner, he told them he was not going to use the patch, and he did not want any of his pain medications changed. Review of Resident #4's progress notes revealed note dated 05/16/2024 at 6:15 AM by LVN O Resident is alert responsive c/o generalized pain, PRN Oxycodone 10 MG 1 tablet PO administered @ 0255, Rx effective no further c/o pain or discomfort, continue ongoing plan of care . Review of Resident #4's progress notes revealed note dated 05/16/2024 at 9:16 AM by LVN G Resident complain of pain. Resident request for oxycodone. Resident did not state how much pain he is experiencing when asked. States ' All my body is in pain. I'M going through withdrawal'. Pain medication administered at 0810. Review of Resident #4's progress notes revealed note dated 05/16/2024 at 12:24 PM by LVN G Resident continues to refuse pain patches. NP aware. RP notified. Interview on 05/15/2024 at 3:44 PM with RN I revealed that she had worked at the facility for about 6 years and was familiar with Resident #4 and had worked his hall for about a week. RN I stated that he comes up to the nurses station every 4 hours to ask for the oxycodone and was unable to describe to her where exactly the pain was, indicated he feels pain everywhere. RN I stated he had a history of back pain due to surgery. RN I stated that she was aware the resident was refusing pain patches and stated one day LVN G had opened a pain patch and was going to make him take the patch and he refused. RN I stated that Resident #4 commonly ambulates with his walker or was in bed and used Bengay to his lower back every day. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 05/16/2024 at 9:26 AM with Resident Representative for Resident #4 revealed resident was initially a short-term resident but transferred to long term care at the facility. Resident Representative stated Resident #4 had previous surgeries to his neck and spine that left him with chronic pain due to the hardware and he had arthritis. Resident Representative stated that she thought the facility staff needed a lot of education on chronic pain syndrome and Resident #4 experienced withdrawal when he did not take his medication regularly. Resident Representative stated the resident was under the care of a pain physician before long term care for [AGE] years and his pain was managed well with no changes. Resident Representative stated she was a participant during the care plan conference it was explained to staff that he takes oxycodone every 3-4 hours for pain. The facility stated they could not give that medication to the resident on a schedule. They could prescribe it as PRN (as needed) and he would have to ask for it every 4 hours because they can not give it around the clock. Resident Representative stated she did not recall any other discussion or questions around pain management or why the resident has chronic pain. Resident Representative stated Resident #4 had mentioned that he had been in more pain lately and that his pain levels have been about a 7 out of 10. Resident Representative stated that a couple of weeks prior, Resident #4 was prescribed a pain patch, a morphine derivative, by the nurse and he called her because he was concerned about the interactions of the pain patch with his oxycodone. Resident Representative stated she spoke with the pain Physician who told her that the patch should be safe and wanted him to be monitored more frequently to ensure he was not feeling lightheaded or dizzy. Resident Representative stated that Resident #4 did not want to try it and did not want his medications changed. Interview on 05/16/2024 at 9:50 AM of CMA J revealed she was aware the resident took oxycodone and gabapentin for his pain and she provided lidocaine patches for the resident. CMA J stated he sometimes refused the lidocaine patch, but other times would use them. CMA J stated she asked Resident #4 where his pain was, he would motion to his neck but also say he has pain throughout his body. CMA J stated she thought his pain was well managed. Interview on 05/16/2024 at 10:05 AM with Resident #4 revealed he stated, they don't seem to understand my pain needs that he needed the oxycodone every 4 hours, or he would experience withdrawals and that when he goes to the nurse's station to ask for the oxycodone he gets anxious and shaky. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 05/16/2024 at 11:18 AM with LVN G revealed she had worked at facility for about 2 years and regularly worked on Resident #4's hall. LVN G stated that Resident #4 asked for oxycodone every 4 hours and that the lidocaine pain patches were prescribed in March. She stated a controlled pain patch was prescribed on 05/03/2024 for pain by the facility's pain physician. LVN G was asked for the name of the physician and LVN G stated actually, it's the Nurse Practitioner who I talk to when Resident #4 refuses the patch. LVN G stated the nurse practitioner for the facility's pain physician was NP EE. LVN G stated the NP EE was onsite at the facility about once or twice a week or as needed. LVN G stated that Resident #4 came to the nurses station every 4 hours and told them that he needs his Oxycodone 15 mg. LVN G stated she asked Resident #4 what is pain level is and where the pain is and he would become upset. LVN G stated that in the past, he told her that his pain was low and if he waited to take the medicine, he will be in pain. LVN G stated that Resident #4 now he says he is at a pain level of 8 or higher and would become very upset about being asked his pain level. LVN G stated she asked resident where the pain is and he would indicate his neck and say his whole body. LVN G stated that Resident #4 had a diagnosis of dementia, Chronic Pain Syndrome and arthritis but was unsure why resident had chronic pain. LVN G stated that Chronic Pain Syndrome was when he will think he is in pain when he isn't and will ask for pain medication because he thinks he needs it. She stated that residents on strong pain medications were monitored routinely for sedation. Which could indicate that a resident was receiving too much pain medication with symptoms, such as respiratory depression or sleepiness, and would be documented in the eMAR or progress notes. LVN G stated that she never observed any signs of sedation and did not think that Resident #4 was excessively dosed with narcotics. LVN G stated that the controlled pain patc [TRUNCATED]

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37028 49427 Based on observations, interviews, and record review, the facility failed to provide food and drink that was palatable and in the correct food form for two (Lunch 05/14/2024, Lunch 5/15/2024) of three meals observed for food palatability and food form. The facility failed to provide a lunch meal on 5/14/2024 and 5/15/2024 that was palatable and that had the puree bread in the correct food form. This failure could place residents at risk of decline in nutrition status, loss of appetite, and decreased intake placing them at risk for unplanned weight loss. Findings included: Observation on 05/14/2024 at 09:30 AM during the initial kitchen tour revealed lunch had already been prepared and was in the warming rack. Interview on 05/14/2024 at 10:56 AM with Dietary Manager revealed breakfast was served at 7:30 AM, lunch at 12:00 PM, and dinner at 5:00 PM. Record review of the weekly menu revealed lunch for 05/14/2024 was Chicken Cordon Bleu, mashed potatoes, gravy, seasoned greens, chilled fruit cup, and ice water. Review of weekly menu revealed lunch for 05/15/2024 was hamburger on bun, seasoned French fries, ketchup, lettuce, tomato, onion, pickles, frosted yellow cake, beverage of choice, and ice water. Review of the weekly menu revealed lunch for 05/16/2024 was chili con carne, fluffy brown rice, seasoned carrots, cornbread, margarine, frosted marble cake, and beverage of choice. Observation on 05/14/2024 at 12:55 PM of lunch test tray for regular and puree diet revealed regular diet was Chicken Cordon Bleu, mashed potatoes, gravy, seasoned greens, chilled fruit cup, and ice water. The puree diet lunch tray contained pureed Chicken Cordon Bleu, puree bread, pureed California vegetables. The puree bread was in ball on the plate, was dark brown, and the texture was tough to cut into with a spoon. The puree' tray was not palatable. Interview on 05/14/2024 at 12:58 PM with [NAME] T revealed she had prepared the lunch meal and tasted the food. [NAME] T stated that the pureed starch was good, spinach could use some salt, and the chicken tasted okay but needed salt. [NAME] T stated the pureed California vegetables could have used more salt and texture could be a little smoother, sometimes the carrots or broccoli can be challenging to get completely smooth. [NAME] T stated that the puree bread was not the right consistency and was too thick for a puree meal, when tasted it stuck to the roof of the Cook's mouth. [NAME] T stated that the longer puree bread sits in the warming rack the more it cooked and became firmer. [NAME] T stated she was the one who prepared the puree meal, and it was important for the puree meal texture to be smooth to ensure residents do not choke. [NAME] T stated the pureed meat tasted okay and it was important that the food tasted good for residents to enjoy their food because it impacted resident quality of life. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/15/2024 at 12:56 PM revealed lunch test tray for regular diet was hamburger, fries, with lettuce, tomato, onion, pickle on the side, and a slice of yellow cake. Observation of puree diet revealed puree bread, puree tomato, puree, mashed potatoes with gravy, and puree yellow cake. Observation of puree bread revealed it was in a slightly ball like shape. The puree tomato did not taste like tomato and was not palatable. Interview on 05/15/2024 at 12:56 PM with the Dietary Manager revealed that the cake's frosting was a glaze. There was no frosting visible on the cake. She stated that some cooks prepared the cake differently than others so sometimes the frosting might be thicker than other times. She stated the cooks follow the recipe and this frosting was made with powdered sugar and milk. The Dietary Manager stated that she expected the cooks to taste the food before it goes out and that she expected staff to modify the food to taste good. In an interview on 05/15/2024 at 1:00 PM with the Dietary Manager revealed puree bread was a little thick and stated it will continue to cook in the steam table and warming rack. Observation on 05/16/2024 at 12:46 PM revealed the lunch test tray for puree diet only was chili con carne, fluffy brown rice, seasoned carrots, cornbread, and frosted marble cake. Interview on 05/17/2024 at 12:45 PM with the Dietary Manager revealed she cooked today, and the bread puree was the correct consistency. The Dietary Manager stated that she made the pureed bread for breakfast and set aside the portion for lunch service. She stated she left it on the counter at room temperature until lunch time and then put it in the steam table where it got up to appropriate temperature instead of placing puree bread in the rack warmer until lunch. The Dietary Manager stated she had added milk to the bread to puree and stated a little bit of milk was okay to leave out at room temperature from breakfast to lunch service unless she added something more like eggs because the eggs could spoil. The Dietary Manager was unable to say if milk was a food that required temperature control for safety. The Dietary Manager stated it was important to keep perishable food at a safe temperature to prevent food illness. Interview on 05/17/2024 at 12:26 PM with the Regional Dietician revealed she had worked with the facility since August 2022 and she visited the facility in-person, 2 days a month to audit kitchen sanitation, sample test trays, and saw residents. She said when offsite she works on resident assessments, diet audits, and supplements. The Regional Dietician stated there were currently 5 residents on a puree diet. The Regional Dietician stated that the broth or milk would be used to blend and thin the bread to the correct consistency. The Regional Dietician stated that puree bread should have a smooth consistency like a thin mashed potato consistency that would hold together on a spoon and not be a thick and solid mass and not so thin it would be like a soup. She stated that the puree rice should be smooth and there should not be any grains. The Regional Dietician stated that it sounded like the education of dietary staff was needed about puree consistency. The Regional Dietician stated that residents on a puree diet cannot have any solid pieces of food because they could choke. Review of corporate recipe- Number:399 titled Puree Bread/Rolls reflected recipe called for ingredients of puree bread mix, water, and vegetable oil. Review of corporate recipe titled Fluffy Rice reflected 11. PUREE INSTRUCTIONS: take 1/2 portion rice, place in blender until smooth. Add broth, milk, and thickener for correct consistency. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's food safety policy titled Nutrition Policies and Procedures dated revised 06/20/2023 revealed Food will be reviewed and stored by methods to minimize contamination and bacterial growth . 8. Transfer foods to their appropriate locations as quickly as possible especially Time/Temperature Control for Safety Foods (TCS) that need to be frozen or stored under refrigeration.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observations, interviews, 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 three (Resident #16, 42, and 50) of six residents observed for infection control. 1. The facility failed to ensure that CNA B performed hand hygiene while providing incontinence care to Resident #16. 2. The facility failed to ensure that CNA E changed her gloves and performed hand hygiene while providing incontinence care to Resident #42. 3. The facility failed to ensure that CNA D performed hand hygiene while providing incontinence care to Resident #50. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Review of Resident #16's Face Sheet dated 05/14/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic kidney disease and pneumonitis. Review of Resident #16's Comprehensive MDS assessment dated [DATE] reflected Resident #16 was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated Resident #16 required extensive assistance for toilet use. Review of Resident #16's Care Plan dated 05/09/2024 reflected resident was at risk of for deterioration in ADL and one of the interventions was provide assistance for ADL. Observation and interview on 05/14/2024 at 1:56 PM revealed CNA C was about to do incontinent care for Resident #16. (continued on next page)

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	676248	A. Building B. Wing	05/19/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA C prepared the things needed for incontinent care. CNA C washed her hands and put on gloves. CNA C then unfastened the tape on both sides of the brief, rolled the front half of the brief down, and then pushed it between the resident's thighs. CNA C cleaned the front part of the resident using the front to back technique. CNA C instructed the resident to roll to the right. CNA C changed her gloves but did not sanitize before putting on the new pair of gloves. CNA C then proceeded to clean the bottom of the residents. After wiping down the resident, CNA C rolled the rest of the brief, pulled it, and threw it in the trash can. CNA C took off the soiled gloves and proceeded to change her gloves. She did not do hand hygiene in between gloves change. CNA C then proceeded to get the new brief, opened it, and placed it at the bottom of the resident. The resident was instructed to roll back. CNA C fixed the brief and fastened the tape on both sides, pulled the blanket up, and gave the call light to the resident. CNA C took off her gloves, threw them in the trash can, and washed her hands. CNA C said she washed her hands before and after doing incontinent care but acknowledged she did sanitize her hands when she changed her gloves. She said she should have taken off her gloves, washed her hands or sanitized her hands, and then put on new gloves after cleaning the resident. She added this could result to cross contamination and infection because the microorganisms from the soiled gloves could transfer to the things touched after incontinent care. 2. Review of Resident #42's Face Sheet dated 05/15/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Review of Resident #42's Comprehensive MDS assessment dated [DATE] reflected Resident #42 had a severe impairment in cognition was cognitively with a BIMS score of 03. The Comprehensive MDS Assessment indicated Resident #42 required extensive assistance for toilet use. Review of Resident #42's Care Plan dated 02/16/2024 reflected resident required assistance with ADL's related to impaired mobility, weakness, cognitive impairment. Observation and interview on 05/15/2024 starting at 11:14 AM revealed CNA E was about to transfer Resident #42 to her wheelchair to prepare for lunch. CNA E told the resident that she would change her first before transferring her to the wheelchair. CNA E washed her hands and put on gloves. CNA E prepared the things needed for incontinent care. CNA E then removed the resident's pants. CNA E took off her gloves and put on new gloves. CNA E then tore the sides of the pull-up, rolled the front half of the pull-up, and then pushed it between the resident's thighs. CNA E cleaned the front part of the resident using the front to back technique. CNA E instructed and assisted the resident to turn to the right and proceeded to clean the resident's bottom. After cleaning the resident's bottom, CNA E pulled the rest of the pull-up and threw it in the trash can. CNA E then proceeded to get the new pull-up and put it on the resident. CNA E did not change her gloves nor wash/sanitize her hands before getting the pull-up. CNA E then put on the resident's pants and proceeded to transfer the resident to the wheelchair. CNA E took off her gloves and threw them in the trash can. CNA E acknowledged she did not sanitize her hands when she changed her gloves and did not change her gloves before touching the new pull-up. She said she should had sanitized in between changing gloves and changed her gloves before getting the new pull-up. She said this could result to cross contamination and infection. She said they had an in-service two weeks prior about hand hygiene. 3. Review of Resident #50's Face Sheet dated 05/15/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. One of the relevant diagnoses was diarrhea. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #50's Comprehensive MDS assessment dated [DATE] reflected Resident #50 was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated Resident #16 required extensive assistance for toilet use. Review of Resident #50's Care Plan dated 04/19/2024 reflected resident required assistance with ADL's related to impaired mobility and one of the interventions assist in toileting. Observation and interview on 05/15/2024 starting at 10:18 AM revealed CNA D was about to do incontinent care to Resident #50. CNA D told Resident #50 that she would be changing him. CNA D prepared the things needed for incontinent care and then put on a pair of gloves. She did not wash her hands. CNA D then unfastened the tape on both sides of the brief, rolled the front half of the brief down, and then pushed it between the resident's thighs. CNA D cleaned the front part of the resident. CNA D instructed the resident to turn to the left. When the resident was on the side lying position, the resident begun to have a bowel movement. CNA D waited for the resident to finish. When the resident was done with the bowel movement, CNA D cleaned the resident's bottom. After cleaning the resident, CNA D rolled the rest of the brief, pulled it, threw it in the trash can, and then changed her gloves. She did not do any hand hygiene. CNA D then proceeded to get the new brief, opened it, and placed it at the bottom of the resident. The resident rolled back and CNA D fixed the brief. CNA D took off her gloves and threw them in the trash can. CNA D then washed her hands. CNA D acknowledged she did not wash her hands before doing incontinent care and did not sanitize her hands when she changed her gloves after cleaning the bottom of the resident. CNA D then pulled a container from her pocket and said she had the sanitizer but forgot to use it. She said it was important to do hand washing before giving care to ensure there was no transfer of any microorganism. She said the same thing was true sanitizing the hands after taking the gloves off. In an interview with RN A on 05/16/2024 at 7:43 AM, RN A stated the right procedure was to wash hands before and after incontinent care, to do hand hygiene in between changing of gloves, to change the gloves after cleaning the bottom of the resident, and before getting the new brief. She said the purpose of the method was to prevent cross contamination and infection. She said microorganisms could easily transfer from soiled hands and gloves. In an interview with the ADON on 05/16/2024 at 7:21 AM, the ADON stated staff should wash their hands before and after doing any care. He said gloves should be changed after cleaning the buttocks of the resident and staff should do hand hygiene in between changing of gloves. he said the risk from improper hand hygiene would be infection and cross contamination. The ADON said the expectation was the staff would remember to wash their hands and change their gloves when transitioning from a dirty area to a clean area. He added the staff must also use the sanitizer that were provided to them. The ADON concluded he would do an in-service and would continually remind the staff to be diligent in making sure the procedures for infection control were followed. In an interview with the DON on 05/16/2024 at 7:35 AM, the DON stated not doing hand hygiene before, during, after incontinent care could result to spreading microorganisms and eventually infection of any kind. She said, herself and the ADON were responsible in ensuring proper hand hygiene were done. The DON said the expectation was the staff would remember to wash their hands, change their gloves when transitioning from a dirty area to a clean area, and do hand hygiene when changing the gloves. She concluded that she would do an in-service about hand hygiene and continually remind the staff of the importance of hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Administrator on 05/16/2024 at 8:34 AM, the Administrator stated hand hygiene was important to prevent infection. He said this should be done so the clean items would not be soiled. He said the staff should be cognizant about washing their hands and changing their gloves when needed. The Administrator said they would re-educate the staff regarding hand hygiene and would monitor for three weeks if the in-service was effective and would do another one id needed. Record review of facility's policy, Hand Hygiene/Hand Washing Infection Prevention and Control Policies and Procedures rev. May 15,2023 revealed Procedures: 1. Hand hygiene/hand washing is done . A. Before patient/resident contact . After contact with soiled or contaminated articles . H. After removal of medical/surgical or utility gloves.