STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676339	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Oaks Therapy and Living Center	3350 Bonnie View Road Dallas, TX 75216

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observations, record reviews and interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and that residents received adequate supervision to prevent accidents for five (Resident #1, #2, #3, #4 and #5) of six resident reviewed for accident hazards/supervision. 1. The staff at the facility failed to appropriately supervise Resident #1 who was allowed to leave the facility whenever he wanted, even though his cognition was severely impaired. 2. On 10/02/23 Resident #1 left the facility at an unknown time and staff did not realize it until around 7:00 p. m., when it was reported to the Administrator. The Administrator did not contact local police until the following day, thereby not following his policy and procedure for a missing resident Resident #1 was found by a neighbor on 10/03/2023 across the street where he used to live sitting in the lot where his house had been torn down. 3. The facility failed to ensure Resident # 2 after a fall, was properly assessed. 4. The facility failed to properly maintain wheelchairs for Residents #3, #4, and #5. It was determined the noncompliance was identified as a Past Noncompliance as an Immediate Jeopardy (IJ). The IJ began on 10/02/2023 and ended on 10/03/2023. The facility corrected the noncompliance before the investigations began. This failure placed residents at risk for harm and/or serious injury. Findings included: Record review of Resident #1's quarterly MDS assessment, dated 08/27/2023 reflected the Resident was a [AGE] year-old-male who admitted to the facility on [DATE] and discharged on [DATE]. The resident had diagnosis which included: Dementia (disease that affects the brain causing confusion), intracranial bleed (bleeding in the brain), cognitive communication deficit (inability to communicate effectively) history of falling, generalized weakness cerebral infarction (stroke). The MDS reflected he had a BIMS score of 6, which indicated sever cognitive impairment and the resident was ambulatory with an unsteady gait, at times requiring a wheelchair and required assist of one staff for activities of daily living. The MDS did not reflect any wandering behavior. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, dated with a review date of 08/27/2023, addressed the resident's impaired cognition due to short term memory loss (unable to remember after 5 minutes), risk for falls and assistance required for activities of daily living. Record review of Resident #1's clinical record revealed no Elopement [NAME] Assessment. Record review of the Provider Investigation Report completed by the Administrator, dated 10/09/2023, revealed Resident #1 was independently ambulatory, own responsible party, could make decision for himself, alert and oriented and had left the faciity on [DATE] (no time reflected) and was noted still gone from the facility on 10/02/2023 at approximately 7:00 p.m. The resident was last seen when he had left the facility earlier in the day. The family was notified, and the police were not called. The facility staff did not search for Resident #1, as the family did not seem that concerned. The family was notified on the night of resident leaving facility. On the morning of 10/03/24, the Administrator contacted the family again and they did not know of Resident #1's where abouts. At that time, the police were called. The resident was returned to the facility on [DATE] by the neighbor that he used to live across the street from. Resident #1 was sitting in front of his torn down house. The Provider Investigation Report reflected a finding of confirmed (for other). Resident #1 was assessed by the nursing staff, no injuries indicated. The facility started in-service on the sign-out procedure policy and procedure with all staff. The facility reassessed all the resident for cognitive function and informed the whole staff on who could sign themselves out and who could not. Residents were informed that no one was to leave the facility unless they had an appointment or out with family. Review of Provider Investigation Report dated 10/09/2023 reflected a finding of confirmed for Other. Review of the External/Internal/Systemic Approach Investigation Summary dated 10/09/2023 completed on 10/09/2023 reflected: . an emergency QAPI meeting was held on 10/03/2023 with Medical Director in attendance . all residents had a new cognitive assessment to identify any current patients that are imminent risk for elopement (no other residents were found to be at imminent risk of elopement) . (who was responsible: Nurse Management . who will monitor: Director of Nursing.cognitive assessment will be completed upon admission and quarterly by the charge nurse and/or nurse managers and for any resident that triggers an imminent risk for elopement, the elopement response protocol will be initiated Any patient that triggers elopement risk will be placed on 1:1 monitoring until no longer deemed necessary. DON will monitor for compliance for 3 weeks until 10/27/2023 and then monthly on an ongoing basis .Who will monitor: Administrator Until alternative and or safe living arrangements are made they will be placed on one-one-supervision with facility staff. Resident care plans will also be updated. The Director of Nursing and/or Nurse Manager will monitor weekly for compliance by completing an audit of the cognitive assessments. Audits will be completed weekly for 3 weeks until 10/27/2023 and monthly on an ongoing basis Monitoring .Starting 10/03/2023 Director of Nursing and/or Nurse Managers will receive in hand, the resident monitoring/every 2-hour body check documentation at the end of each shift for the first 72 hours, each day for one week, then weekly for 4 weeks. The Administrator will review the documentation each week for compliance The Administrator will monitor daily to ensure compliance for four weeks and will review . Further review of the Providers Investigation Report reflected monitoring and audits by the designated staff (DON Nurse Managers) had occurred. Record review of nursing progress notes from 08/01/2023 until 10/03/2023 reflected Resident #1 only signed out two times for pass, once on 08/15/2023 when he was encouraged to take his wheelchair, (he declined) and returned later in the morning with and an abrasion to his elbow, stated he had fallen. On 10/02/2024 when he signed himself out and did not return to the facility. Further review of the progress note reflected Resident #1 was transferred to another facility that had a secured unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of progress notes reflected Resident #1 on 10/02/2023 at 7:22 p.m., LVN K had noted he had signed himself out and left the facility. Further review reflected that LVN K had informed the DON (at that time), multiple times during the shift of Resident #1 not returning and was informed he was his own responsible party. LVN K documented in her nurses notes she had notified the family and the Administration of Resident #1 not returning to the facility at 11:10 p.m. Record review of the progress notes reflected Resident #1 on 10/03/2024 at 4:25 p.m., had still not returned to facility. LVN L documented the police had been notified. Further review reflected Resident #1 was brought back to the facility on [DATE] at 5:50 p.m., by a neighbor, that used to live across the street from him. He was assessed with no injuries noted. Resident #1 was hungry and thirsty. Resident #1 told the police officer that arrived he did not want to go to the hospital, when asked about where he was, Resident #1 stated he had walked to his old house, that was not there anymore and had slept on the grass that night. Further documentation reflected he was cleaned up, fed, given something to drink and was placed in bed by 10:30 p. m. Review of In-service dated 10/03/2023 reflected all staff attended and the subject matter was regarding Facility policy on the residents signing themselves out and the elopement and reducing the risk for elopement: initiating a frequent monitoring form and updating the care plan. In an interview on 04/29/24 at 11:30 a.m. with LVN Q revealed the residents could not just sign themselves out. There were only two residents that could do that. The rest of the residents had to have a doctors appointment with a family member to go or the family checks them out, they could not just go out the front door. LVN Q stated she had been in-serviced when she started working at the facility. In an interview on 04/30/2024 with MA A at 8:49 a.m. revealed she had worked at the facility off and on for the past 7 years, she recalled Resident #1 he was very pleasant man, unsteady on his feet at time, and was incontinent. MA A stated he was not always alert and oriented, he would not even change himself. He required assistance of the staff to help him change his clothing, shower and help change his briefs. MA A stated she had observed him many times walking towards the front of the lobby, and she would get him bring him back and change him and help him clean up. MA A stated she had reported her concerns to the nurses, the DON at the time, and the Administrator at the time, but they told her the resident was his own responsible party and he could go out. MA A stated she felt like he could if he was accompanied, but they said no he could go out on his own his family knew about it. MA A stated it was not long after that he left the building and he did not return. MA A took the in-service from the new Administrator and informed him about the cognition of Resident #1 and he thanked her and said the other Administration should have listened to her. MA A stated she had been in-serviced that no resident is to leave the facility and be allowed to sign themselves out that is not on the list. There are only two residents that can sign themselves out now. The rest of the residents either have to have approval from the DON or the Administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/30/24 at 9:22 a.m. with the Administrator at 9:22 a.m. revealed he had just started working the facility in September and he did not know the residents very well. The Administrator stated he was unaware they were just letting any and all sign out of the facility if they were their own responsible party. He was notified that night, by one of the nurses, when Resident #1 had not returned, she told me she had contacted the family to let them know. He recontacted the family and they did not seem at all concerned they stated he was probably at one of the relatives that live in the neighborhood. The facility did not hear back from the family until the next day the charge nurse heard from a family member, and he had not heard from the family, and did not know where Resident #1 was. The Charge nurse informed me and informed the police. The Administrator stated that was in the evening. The Administrator stated he had then started the investigation. The Administrator stated and at the time the first part of his investigation was completed, a neighbor, who used to live across the street from him bought him back to the facility. The facility monitored the resident until they found another facility that would take him that had a secured unit. The Administrator had the DON (at a that time) complete an in-service concerning signing out and an assessment of all the residents' cognitive status and elopement. He told the staff that no resident was allowed to sign out of the facility unless they had his permission to do so. He stated they currently have two residents that can sign themselves out. The Administrator stated at the time this incident occurred, he had no idea the cognitive level of Resident #1 or the resident would never been allowed to leave this facility without being accompanied. In an interview and observation on 04/30/2024 at 11:00 a.m. with the DON revealed that if a resident had left the facility, which should not be leaving, the staff should notify, her and the Administrator immediately. The staff is supposed to immediately start looking for the resident and call the police. The DON stated if she had been working here when Resident #1 lived here he would not have been allowed to leave the facility on his own. The DON stated she didn't understand why they did not call the police right away. The DON and Surveyor revealed the sign in sign out log located at the nurses' station dated back to January 2023. There were no noted sign outs in the book for Resident #1. The DON stated there were only two resident that were allowed to sign themselves in and out. The DON stated that all residents had been cognitively assessed. The two resident that could sign themselves in and out had been informed of the policy and if they did not follow the policy they could not go out. The DON stated at this time there are no wanderers or elopement risk in the facility. In an interview on 04/30/24 at 11:20 a.m. with CNA C revealed the CNA had been in-serviced on the process concerning residents signing out and who could and who could not. The CNA stated that the new process was not anyone could just sign out, you had to ask the charge nurse and the resident had to be stopped before they could leave. The residents could no longer just go out the front door. CNA C stated she had been in-serviced on the elopement process and knew what to do. In an interview on 04/30/24 at 11:45 a.m. with CNA M revealed she had been in-serviced on the elopement process and what to do and what to do when a resident wants to sign themselves out to go somewhere. In an interview on 04/30/2023 at 12:15 p.m. with the Administrator revealed there had been cooperate intervention, when he requested, when this occurred. The Administrator stated he had been informed that the cooperate policy was if the resident is their own responsible party they can sign themselves out of the facility. The Administrator stated when he attempted to find the policy for that online he had been given no access to review any policies and still could. Not access the policies at the time of this visit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation on 04/30/24 at 4:00 p.m. revealed the surrounding outside area, parking lot, and streets adjacent to the facility. The facility was in an industrial/residential area with multiple stores, a high school, and multiple businesses. The street in front of the facility was very busy. Dump trucks and were observed driving down the street. There was a popular street less than a third of a mile away, as well as a very busy main four lane street that leads to residential areas, and large shopping centers, that has heavy traffic on the road all times of the day and night. Where the resident was found is approximately three- and one-half miles away through busy streets, businesses, and residence. Attempts were made to contact the previous employees LVN K and LVN L on 04/30/2024 at 1:00 p.m., 3:00 p.m., and 4:45 p.m. Messages were left, with no return calls. Attempts were made to contact the previous DON on 04/29/2024 at 11:00 a.m. and 1:45 p.m., and on 04/30/2024 at 3:00 p.m. Messages were left with no return calls. Attempts were made to contact the previous Administrator on 04/29/2024 at 3:30 p.m., 04/30/2024 at 10:00 a.m. and 2:00 p.m Messages were left with no return calls. Attempt was made to return call to the Medical Director on 04/29/2024 at 11:30 a.m. without success and a message was left. The Medical Director did return call and stated he was made aware of the resident being transferred to a secured unit due to his change in condition and elopement. The Medical Director stated he was not aware of the cognition level of Resident #1, and he was leaving the facility by himself for pass. Record review of Resident #2's quarterly MDS assessment, dated 02/21/24, revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included Dementia, Delirium Due to Known Physiological Condition, Generalized Idiopathic Epilepsy, Repeated Falls, and History of Traumatic Brain injury. The cognitive section C100 of the MDS indicated Resident #2 had severe cognitive impairment. She had symptoms of inattention, disorganized thinking, altered level of consciousness and wandering. She had an unsteady gait and required a wheelchair for mobility. Record review of Resident #2's Care Plan dated 12/16/23, revealed a problem identified as Falls; I am at risk for falls related to unsteady gait/balance, wandering, lack of safety awareness. Resident #2 will remain free from minor injury on a daily basis. Another problem was identified as Resident #2 has an ADL Self Care performance Deficit related to confusion, dementia and impaired balance. With a goal that described Resident #2 will maintain current level of function in bed mobility, transfers . With interventions listed as Transfer, Resident #2 requires Limited Assistance from (1) staff participation with transfers. In an observation on 04/29/24 at 11:16 AM a resident pointed out Resident #2 on the floor in a common area in front of a regular chair and Resident #2's wheelchair. Facility staff was alerted Resident #2 was on the floor. CNA B entered the common area and asked Resident #2 if she was hurt. CNA B then lifted Resident #2 from the floor and placed her in a regular chair. CNA B moved the wheelchair closer to the resident, applied the brakes to the wheelchair and then picked up Resident #2 from the regular chair and transfered Resident #2 to the wheelchair. CNA B then pushed Resident #2 out of the common area and into Hallway 400. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/30/24 at 11:30 AM Hospitality Aide G stated she had received training in responding to residents that had fallen. She stated that if she found a fallen resident, she would make sure the resident was safe, then she would find a nurse first and that she knew that if she moved a resident after a fall, it could hurt a resident further. In an interview on 04/30/24 at 11:34 AM Treatment Nurse stated that the facility does training for resident falls. She that a CNA should never move a resident until instructed by a nurse after the resident has been assessed and is determined safe to be moved. In an interview on 04/30/24 at 11:36 AM LVN E stated that she had received training for falls at the facility several times. She stated that CNA's and all staff are aware that if a resident falls the resident cannot be moved until a nurse completes an assessment. In an interview on 04/30/24 at 11:45 AM CNA C stated that she had received training in falls at the facility. She stated that they are not supposed to touch the resident unless a nurse assesses the resident first. She stated that you can only move them or things around them to prevent further injury first, but you can't move the resident until a nurse sees them. In an interview on 04/30/24 at 11:50 AM CNA D stated that she had received fall training and that you cannot move a resident until a nurse has assessed a resident first because you might hurt them more if you do. In an interview on 04/30/24 at 12:03 PM DON stated the proper procedure for falls is for the CNAs to make sure the resident is safe, and not to touch or move the resident before a nurse assesses the resident and to notify a nurse immediately of a fall. She stated that if a resident is moved before being assessed it could injure a resident more if they had a fracture or some other type of injury. She stated all staff have been trained in the procedures for falls. In an interview on 04/30/24 at 12:23 PM LVN F stated that if any resident has a fall the 'CNA's or whichever staff member finds the resident are to secure the area for the resident and then get the attention of a nurse to come and assess the resident before the resident can be moved. In an interview on 04/30/24 at 1:34 PM CNA B stated that she had received training for falls several times and knew that she should not have moved the resident. She stated that she was very nervous in front of the investigators and completely forgot to have the resident assessed before picking up the resident. She stated that she knew the resident had been assessed later and that she was thankful the resident was not injured. Review of Resident #3's quarterly MDS assessment, dated 12/27/23, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of congestive obstructive disorder (respiratory ability to breath), congestive heart disease (heart disease), and right below knee amputation. Further review of the MDS reflected the resident was cognitively severely impaired and unable to make decisions for themselves. Review of the Resident #3's plan of care dated 12/30/23 with updates reflected goals and approaches to include wheelchair mobility for locomotion. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 04/29/24 at 1:30 p.m., revealed Resident #3 was sitting in her wheelchair, in the dining room and had no skin problems. The wheelchair's right armrest was cracked with foam exposed. There was dried food substances on the back of the wheelchair. Review of Resident #4's quarterly MDS assessment, dated 04/09/24, reflected she was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses of paranoid schizoaffective (mental illness), muscle weakness (muscle deterioration), traumatic brain injury (brain injury), and diabetes (increase in your sugar level). Further review of the MDS reflected the resident was cognitively severely impaired and unable to make decisions for themselves. Review of the Resident #4's plan of care dated 03/27/24 with updates reflected goals and approaches to include wheelchair mobility. Observation on 04/29/24 at 12:45 p.m., revealed Resident #4 was sitting in her wheelchair in the dining room and the wheelchair's left and right armrests were cracked with exposed foam. There were no skin tears on arms. The wheels of the wheelchair had dried food substance on both wheels and on wheel rims. Review of Resident #5's quarterly MDS assessment, dated 02/22/24, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses of Hemi-left dominant side (cannot use that side) convulsions (seizures), abnormalities of gait and mobility (unable to mobilize safety), and depression (mental illness). Further review of the MDS reflected the resident was alert and oriented and able to make decisions for themselves. Review of the Resident #5's updated plan of care dated 04/19/24 with updates reflected goals and approaches to include wheelchair mobility. Observation and interview on 04/29/24 at 10:32 a.m., revealed Resident #5 was in her wheelchair in the hallway, and the wheelchair's right and left armrests were missing. The back of the wheelchair was frayed and had an open cracked back. There were no skin tears on the arms. There was dried food particles in the cracked area of the back of the wheelchair. Resident #5 stated the back of the wheelchair did not bother her, but she would like to have some armrests on this wheelchair, she did not want another wheelchair this one was big enough for her. In an interview on 04/29/24 at 11:05 a.m., LVN M stated when a resident's wheelchair needed repair the staff were to report it to the maintenance supervisor. LVN M stated he had only worked at this facility for 5 days, but that was what he would have done at other facilities. LVN M was unaware of any maintenance log or system to be used to report broken equipment. In an interview on 04/30/24 at 9:00 a.m., the with Operation Director revealed the staff tells him if equipment needs repair, but he could tell me that he did not have any equipment to repair the wheelchair at this time. In an in interview on 04/30/24 at 9:30 a.m., with the Administrator revealed he was not aware of any wheelchairs that required repair in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unable to review of the Facility's Policy titled Maintenance or the facility's policy for Assist devices and Equipment, as the Administrator had no access to the policies online. The Administrator forward the request for policies to the cooperation, as of the time of exit no policies had been supplied. Unable to review of the Facility's Policy titled Abuse protocol or the facility's policy for Elopement Response, Maintenance, Assist of devices and Equipment and Falls as the Administrator had no access to the policies online. The Administrator forward the request for policies to the cooperation, as of the time of exit no policies had been supplied. 44021

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on observation, interview and record review the facility failed to store, prepare and serve food with professional standards for food safety in the facilities only kitchen. 1) The facility failed to ensure that foods were not spoiled and past their recommended expiration/use dates. 2) Staff failed to effectively prevent the entry of pests/flies in the kitchen 3) The facility failed to maintain equipment/structures in good working order. These failures could place residents who ate from the kitchen at risk for food borne illnesses. Findings included: 1) Observation and interview on [DATE] at 9:10 AM revealed two bags of prepared salad were observed to be spoiled and foul smelling in the walk-in refrigerator. One bag had a tear in the plastic exposing it to contamination, both bags were labeled with the date [DATE]. Kitchen Manager took both bags of salad out of the walk-in refrigerator space and discarded them immediately. The Kitchen manager stated that the salad was spoiled and that the bag that was open was past its expiration date. She stated that spoiled/expired foods should not be stored/used as spoiled/expired foods could expose residents to food borne illnesses. 2) Observation on [DATE] at 9:14 AM revealed two live flies were noted flying around the dishwashing area, a window was observed to be open next to the dishwashing station and the window had no screen. Observation on [DATE] at 12:11 PM revealed two live flies were found flying in the dishwashing area. Several live gnats were observed flying/resting on surfaces below the dishwashing area. A window with no screen was observed to be open near the dishwashing area. A live fly was observed flying in the food preparation area. 3) In an interview on [DATE] at 9:18 AM the Kitchen Manager stated the plate warmer was not functioning, the deep fryer was inoperable, only 1 of the 4 ovens in the kitchen area were operable and only 4 of the 6 burners on the stove were functioning. She stated that the garbage disposal in the dishwashing area was not functioning. Observation in the kitchen on [DATE] at 9:20 AM the entire wall behind the steam table area was observed to be missing tiles at the baseboard and the floor. The entire base of the wall was covered in grime and the drywall was exposed and appeared to be missing several chunks in various areas along the base. The floor beneath the wall was exposed, water and food particles could be observed under the wall. The other side of the wall also was missing nearly the entire baseboard and the drywall was exposed presenting porous areas that could not be properly cleaned/dried. (continued on next page)

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	676339	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Oaks Therapy and Living Center	3350 Bonnie View Road Dallas, TX 75216

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 3:08 PM [NAME] H stated the kitchen has only had one working oven for nearly two years., She stated that they could not use the deep fryer because the pilot light would not function properly, and she was unsure if anything was ever going to get fixed. She stated that was the problem with the ovens too. In an interview on [DATE] at 12:34 pm with the Operations Manager (OPS) stated that he was aware of the malfunctioning kitchen equipment but that funds have not been available to repair or replace the equipment. In an interview on [DATE] at 4:06 PM with the ADM he stated that he was aware of the equipment issues in the kitchen and the owner had not yet made the funds available to address the kitchen repairs. The Food and Drug Administration Food Code (FDA) dated 2017 reflected, ,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE].11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46525 Based on observation, interview and record review the facility failed to maintain clinical records that were complete and/or accurate for one (Resident #12) of three residents reviewed for clinical records. The facility failed to document a colostomy bag change for Resident #1 was completed on 04/08/24 - 04/09/24 on the 10 PM- 6 AM as well as on the 2P-10 PM shift for every 72 hours, from 04/01/24 to 04/21/24. This failure could place residents at risk for having inaccurate documentation/records which could lead to double treatments, misconceptions that the treatment was not done by other members of the interdisciplinary team, and lack of appropriate care. Findings included: Record Review of Resident #12's admission MDS dated [DATE], revealed the resident was a [AGE] year-old male who admitted on [DATE] with a diagnosis of acuter respiratory failure with hypoxia, encounter for attention to colostomy, unspecified schizoaffective disorder. He has a BIMS score of 13 (no cognitive impairments) Record Review of Resident #12's Care plan dated 03/21/24 revealed a colostomy care plan with the following interventions: change as needed if loose or leaking, change colostomy bag every 72 hours and a goal of my dignity will be maintained, and the ostomy will remain patent and functional on a daily basis. Record Review of progress notes dated 04/08/24 at 19:09 revealed the following, Resident colostomy back needed to be changed, this nurse could not find the back in the med room or central supply and instructed the CNA to keep resident clean and dry to prevent cross-contamination. Resident was consistently cleaned. Record Review of Resident #12's Physician's orders dated 09/27/23 and 04/22/24 revealed an order to change colostomy bag every 72 hours and a physician's orders dated 09/27/23 to change colostomy bag when needed. Record Review of Resident#12's Treatment Administration Record (TAR) dated 04/01/24-04/30/24 revealed there was no signature/initials on the date of 04/08/24 to show that the colostomy bag was changed on that date. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #12 on 04/29/24 at 10:45 AM revealed the following, he was primarily independent resident that can voice his needs, but he requires assistance with the emptying and changing of his colostomy bag. Observation during this time revealed Resident #12 was noted standing at the ice chest, on the 400 Hall, across from his room, filling his cup with ice then he returned to his room. There was no use of any assistive devices, he was fully dressed and had on corrective glasses. He was clean and no mal odors noted coming from him or his room. Resident #12 was able to show his colostomy bag by elevating his shirt; a clean patent and pink ostomy was noted as well as the bag was empty and clamped at the bottom. Resident #12's skin surrounding the site was clean and dry and no signs of excoriation breakdown. Resident #12 stated he has been here about 5 months. He stated he likes it just fine, food is fine. He stated he is independent and mostly does for himself. The staff helps him as needed. Resident #12 stated he was getting medication on time. He stated at the beginning of April 2024, staff would take a long time to come changed or assist with colostomy bag. Resident #12 stated it he usually asked the nurse for assistance. He stated the longest he has waited for assistance with the colostomy was 2p-8 pm, on one day (04/08/24). In an interview with LVN F on 04/30/24 at 10:33 AM revealed the following, he was a new employee but stated if he gives a treatment or changes a dressing or something, he either signs off on the order in the system or writes a note. He said, we have to chart to show it was done or what happened. In an interview with CNA M on 04/30/24 at 11:14 AM revealed the following, she stated as far as the CNAs are concerned when it comes to patient/resident care they do access the resident's record in the EHR (electronic health record). CNA M stated they (staff) do sign off in the system (EHR) when they (staff) complete a task for a resident or a resident refuses care or treatment. In an interview with DON on 04/29/24 at 04:47 PM revealed the following she was the nurse taking care of Resident #12 on 04/08/24 for the 2 PM- 10 PM shift. The DON stated the nurse scheduled for that shift called in, so she filled in. She stated she was Resident #12's nurse, and the CNA came to her and reported that he wanted to have his colostomy bag changed. The DON said, On that day the CNA came to tell me that the resident needed a colostomy bag change. I looked in the med room, but I could not find a colostomy bag in the med room. I told the CNA to keep cleaning the resident to prevent cross-contamination. I told the 10P-6 AM nurse to tell her the first thing she needed to do was change the colostomy bag. I told her I looked everywhere, central supply and the med room. She knew that the bags were in the central supply office, but I didn't know that. If I knew it I would have taken it and changed the bag. I told the CNA to wash the shirt he was wearing. She did and hung across the bar in the bathroom to keep the stain from setting until they could do the laundry. The resident did not have any breakdown as a result of this, I looked in on him the next day. When I texted the 10p -6 AM nurse, she came in an took the bag from the office. I suggested (to SCCS) we put some on the med carts. When she (night nurse) came she changed the bag. She (LVN P) was used to where they keep the supplies, but I did not know, being new here. The next day the niece came, and we talked about it. I explained to that niece that we have it, but I just did not know that they kept them in the central supply office. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 04/30/24 at 02:43 PM revealed the following, the DON said, I called the nurse to make sure the ostomy was changed. The nurses do have keys to the med room where the ostomy supplies are kept. the nurse stated it was changed. I asked why she did not document, she gave me excuses. I did an in-service the next day that anything we do for the residents we document. When I came here (to work at this facility), documentation was an issue. I have told the staff that we document everything. It is getting better on documentation. I know they are getting better. My ADON and Myself are doing monitoring of the charting. Every morning we are doing clinicals before I got here, they were not doing clinical rounds. On the clinical rounds we check every morning. For LVN P, a 1:1 re-education was done regarding charting by the ADON. The DON stated her expectations of the staff is to document what they do. If there is no documentation, then it was not considered done. She stated she is working on ensuring the staff does this. Record Review of the facility's Charting and Documentation Compliance Policy version:, revised May 2017 reflected Policy Statement: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. 2. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants are to document in the EMR in the POC tab. Certified Nursing Assistants are to document all Activities of Daily Living prior to leaving their shift for the day. 3. All incidents, accidents, or changes in the resident's condition must be recorded. 5. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records. 6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment, d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated; g. The signature and title of the individual documenting. 7. Staffing Coordinator will arrive to facility no later than 0830 am. Staffing coordinator will run audit reports from the previous day's documentation for each shift. a. Clinical Tab b. Reports c. POC d. Audit Report e. Enter Shift f. Enter Position C.N.A. g. Date Range- Yesterday's Date (Or the dates being reviewed) h. Documentation Type- Missing i. Report On- Tasks (If you put Interventions, it will run the report wrong. Aides don't chart on interventions) j. Leave Task section blank. If you leave it blank, it runs all tasks k. Run Report- Top Right Corner l. If all documentation was completed for the time frame you are looking for, you will get a blank report that reads No Records Found. m. See attached example of PWD Audit report dated 5.22 showing No Records Found. 8. Staffing Coordinator will bring audit reports to clinical meeting at 0845 to give Nursing Managers an overview of the previous day's documentation status and to discuss calls that need to be made to staff if documentation did not get completed. a. Staffing Coordinator will call appropriate employees and instruct employee to complete the missing ADL documentation before end of day. b. Prior to leaving for the day, Staffing Coordinator will turn in completed Audit Reports, showing NO MISSING DOCUMENTATION, to CNO or other appointed nursing manager. 11. MDS Coordinator will run ADL Audit Reports weekly to ensure that all of the above compliance systems are effective and to capture any late entries per appropriate regulatory guidelines. 12. Nursing Managers will prepare and review during monthly QAPI meetings and ensure that all opportunities or compliance issues are captured and discussed as appropriate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of three (CNA O) staff members reviewed for infection control procedures. CNA O failed to perform hand hygiene after direct contact with residents while serving meals on the hallways. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #6's annual MDS assessment, dated 04/25/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #6 had diagnosis which included: dementia (brain confusion), Parkinson (muscle and nerve disease), and diabetes (increased sugar levels). Resident #6 had moderate cognitive impairment and required assistance of one staff for activities of daily living. Record review of Resident #7's annual MDS Assessment, dated 03/22/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7 had diagnosis which included: dementia (brain disease that effects memory and behaviors), atrial fib (abnormal heart rhythm), hypertension (increased blood pressure), and depression (mood disorder). Resident #7, severely impaired for cognition and required one staff for assistance with activities of daily living. Record review of Resident #8's annual MDS Assessment, dated 04/20/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #9 had diagnosis which included: Cardiovascular accident (stroke), heart failure, atrial flutter (irregular rhythm of the heart), and diabetes (increased sugar levels). Resident #9 was severely impaired for cognition and required one staff for assistance with activities of daily living. Record review of Resident #9's annual MDS Assessment, dated 03/15/24, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #9 had diagnosis which included: Hypertension (high blood pressure), depression (mental illness), and hypothyroidism (low thyroid function). Resident #9 was cognitively able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #10's 5-day MDS Assessment, dated 04/18/24, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #10 had diagnosis which included: Cellulitis (infection of the skin), diabetes (increased sugar), bipolar disorder (mental illness), and venous insufficiency (poor circulation to the lower legs). Resident #10 was cognitively able to make decisions and required assistance of one staff for activities of daily living. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #11's quarterly MDS Assessment, dated 04/30/24, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #11 had diagnosis which included: Cerebral infract (stroke), diabetes (increased sugar), chronic kidney disease (failing kidneys). Resident #11 was severely impaired for cognition and required assistance of one staff for activities of daily living. Observation on 04/29/24 beginning at 12:30 p.m. revealed CNA O had adjusted her clothing, did not use hand sanitizer, and served a lunch tray to Resident #7, touched, and moved the overbed table in the resident's room, touched the hand and shoulder of Resident #7 and prepared the meal tray for the resident to eat his breakfast. CNA O did not have on gloves. CNA O was observed to not wash her hands or use hand sanitizer, available in the hallway. CNA O walked out of the room and came back into the room served the roommate Resident #8's lunch tray. CNA O touched Resident #8's overbed table, she adjusted the head of the bed, touched the pillow behind Resident #8's head. CNA O left the resident's room without washing her hands or using hand sanitizer, entered Resident #9's room to serve lunch tray. CNA O climbed over the back of the bed to get the overbed table positioned correctly and then served the lunch tray, CNA O climbed back over the back of the bed and then assisted Resident #8 with tray set up, leaving room without washing hands or using hand sanitizer. Observation on 04/29/24 beginning at 12:45 p.m., CNA O was observed adjusting her clothing without sanitizing hands. CNA O was observed to enter Resident's #9, # 10, and #11 rooms setting up the resident's lunch trays, adjusted the overbed table, and unwrapped the utensils removed tops off drinks, for each resident. She did not complete hand hygiene before going to the next resident. An interview on 04/29/24 at 1:45 p.m., CNA O stated she did not complete hand hygiene after having direct contact with residents. CNA O stated she was supposed to use the hand sanitizer in between serving each tray from the hall cart. She stated she washed her hands after having direct contact with the residents. CNA O said she had been educated on completing hand hygiene. CNA O stated she did not sanitize her hands, because she was nervous and trying to get the lunch trays served. An interview with the DON on 04/29/24 at 1:13 p.m. revealed that all staff must complete hand hygiene after having contact with residents. She stated CNAs were trained to use hand sanitizer between each tray that was served when they went in the room and when they came out of the room. The DON stated if the CNAs do not use appropriate hygiene, they can spread germs to the residents and themselves. Record review of the in-service logs revealed CNA O received handwashing and hand sanitizing training, dated 02/19/24. Unable to review of the Facility's Policy titled Infection control as the Administrator had no access to the policies online. The Administrator forward the request for policies to the cooperation, as of the time of exit no policies had been supplied.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44021 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for one of one kitchen and one of two common areas (common area near the nurse's station) reviewed for pests, in that: 1. Houseflies and gnats were seen in the common area by the nurse's station, landing on residents and commonly touched surfaces. 2. Houseflies and gnats were present in the kitchen. 3. No pest control contract or treatments for a period of time. This failure placed residents at risk of infection, discomfort, and diminished quality of life. Findings included: Observation on 04/29/24 at 9:13 AM two live houseflies were observed flying near the dishwasher area of the only kitchen in the facility. A window in the dishwashing area was observed to be open and the window was not equipped with a screen allowing ingress of insects. Observation on 04/30/24 at 11:28 AM two live house flies and several gnats were observed around the main nursing station in close proximity to a common area for residents on the 100 hall, one of he flies was noted to have landed on a resident and the resident swatted it away. Observation on 04/30/24 at 12:23 PM two live flies were observed flying in the dishwashing area, several live gnats were observed flying/resting beneath the dishwashing area. A live fly was noted flying in the food preparation area. A window was found to be open next to the dishwashing area and the window had no screen to keep out insects. In an interview and record review on 04/30/24 12:34 PM the Operations Manager (OPS) stated that the former pest control contract had ended on 10/26/23 and that the last visit from the from the former was on that same day. He stated that the new pest control company started to service the facility 02/01/24 with their last visit to service the facility on 4/27/24. He stated that he was not aware that the window in the kitchen area was missing a screen. Record review revealed that the facility did not have an active contract/visits from 11/1/23 to 02/01/24. He stated that the facility did not have any real pest issues during that period of time and that he could apply pesticides to the outside of the building if needed. 04/30/24 at 12:37 PM requested to the Operations Manager (OPS)for the Pest Control Policies, the facility was unable to supply policies before the conclusion of the investigation.