STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676459	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sedona Trace Health and Wellness Center	8324 Cameron Road Austin, TX 78754

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interviews and record review, the facility failed to ensure the residents rights to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 2 of 3 residents (Resident #50 and Resident #71) reviewed for advanced directives. The facility failed to ensure Resident #50's out of hospital do-not-resuscitate (OOH-DNR) form included the resident's printed name and date signed. The facility failed to ensure Resident #71's Medical Power of Attorney (MPOA) included all pages and was signed, dated, and witnessed or notarized to confirm it was valid. These failures could place residents at-risk of having their wishes dishonored or delay necessary medical treatment or intervention due to confusion regarding authority to make medical decisions on behalf of the resident. Findings included: Record review of Resident #50's face sheet dated 06/13/2024 reflected an initial admitted [DATE] with diagnoses of unspecified dementia, hypertensive chronic kidney disease, and major depressive disorder. Review of Resident #50's care plan dated 08/19/2022 reflected the residents elected DNR status. Review of physician's orders for Resident #50 revealed an order for DNR with a start date of 07/13/2023. Record review of Resident #50's clinical record revealed an OOH-DNR which lacked the resident's printed name and date signed under section A. Record review of Resident #71's face sheet reflected an admitted [DATE]. Review of Resident #71's undated MPOA revealed this document did not include Resident #71's signature witnesses by two individuals or a notary therefore rendering it incomplete and invalid. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #50 on 6/12/2024 at 9:12 AM, he stated that he had an OOH-DNR in place. During an interview on 6/12/2024 at 2:46 PM, the SW stated that an OOH-DNR should be dated and have the printed name of the resident. SW answered no when asked if it was missing the date and resident's printed name. SW reviewed Resident #71's MPOA and acknowledged it was missing signature of Resident #71 and witness or notary signature. SW stated that Resident #71's daughter does not live close by, and the document was what was provided. SW stated that she does not have a signature page for #71's MPOA document. SW stated she believed the MPOA needs to have the signature page to be valid. SW did not have a response when asked how she knew the MPOA was valid without the signature page. During an interview on 06/13/2024 at 2:15 PM, the DON stated that the facility social worker was in charge of advanced directives. The DON stated that an OOH-DNR was absolutely not valid if it was missing dates or the printed name of the resident. When asked if a MPOA was complete or valid if it was missing signature pages, the DON stated no it was not valid or complete. The DON stated that it was her expectation that all advanced directives entered into the resident's record be valid. The DON stated that the potential outcome of having incomplete or invalid advanced directives was that a resident's wishes have the potential to not be honored and the facility may not be aware of who to contact. During an interview on 06/13/2024 at 2:48 PM, the ADM stated that the SW was responsible to ensure advanced directives were complete and valid. The ADM answered no when asked if and advanced directive and/or MPOA was complete if it was missing a signature page. When asked if an OOH-DNR was considered valid if it was missing a date or printed name, the ADM answered no. The ADM stated that the facility could go against the resident's wishes as a potential outcome if the resident had an invalid document. Review of facility policy titled Advanced Directives and Associated Documentation with revision date of 01/2023 revealed it is the policy of this facility to implement the resident decisions and directives that are in compliant with State and/or Federal Law and the policies of this facility. Further review revealed that it is the facility's policy to review the Advanced Directive to validate the document reflects the resident choices and that the document is signed and dated by the resident or responsible agent. Review of health and safety code 166.083(b)(3) revealed an OOH-DNR form must contain the printed or type name of the person. Review of Texas DSHS Instructions for Issuing an OOH-DNR Order revealed if an adult person was competent and at least [AGE] years of age, he/she will sign and date the Order in Section A. Review of health and safety code 166.154(a)(b)(c) dated 09/01/2009 revealed the medical power of attorney must be signed by the principal in the presence of two witnesses or have the signature acknowledged by a notary public; witnesses must also sign the document.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interviews and record review, the facility failed to complete a comprehensive, accurate, and standardized reproducible assessment for 2 (Resident #86 and Resident #88) of 3 residents reviewed for comprehensive assessments. The facility failed to include Resident #86's cancer diagnosis in the comprehensive assessment. The facility failed to include Resident #88's depression diagnosis in the comprehensive assessment. This failure could place residents at risk of not having their care and treatment needs assessed to ensure necessary care and services were provided. Findings included: Record review of Resident #86 face sheet dated 6/12/2024 revealed an admitted [DATE] with diagnoses of unspecified fracture of left femur (traumatic injury to femur), acute respiratory failure (when one does not receive sufficient oxygen throughout the body), schizophrenia (a mental disorder characterized by disruptions in thought process), bipolar disorder (serious mental illness that causes unusual shifts in mood), and unspecified lump in the right breast. Record review of Resident #86's MDS assessment dated [DATE] revealed a BIMS score of 11 which indicated a moderate cognitive impairment. Section I of MDS reflected that cancer was not selected as an active diagnosis for Resident #86. Record review of physician's orders for Resident #86 revealed an order for Anastrozole Tablet indicated for breast cancer. Record review of Resident #86's care plan reflected no information regarding her cancer diagnosis. Record Review of Resident #88's face sheet reflected an admitted [DATE]. Further review reflected diagnoses of nontraumatic subarachnoid hemorrhage (bleeding in the space between the brain and membrane that covers it), unspecified dementia (dementia without a specific diagnosis), anxiety disorder (mental health condition in which a person may respond to situations with fear or dread), and cognitive communication deficit (trouble reasoning and making decisions while communicating). Record review of Resident #88's quarterly MDS reflected a BIMS score of 03 which indicated severe cognitive impairment. Section I of Resident 88's quarterly MDS reflected that depression was not selected as an active diagnosis. Resident #88's quarterly MDS reflected an active diagnosis of anxiety disorder. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #88's physician orders revealed an order for Amitriptyline indicated for depression with a start date of 05/14/2024. Further review revealed an order for Mirtazapine indicated for depression with a start date of 05/14/2024. Resident #88 was also prescribed Xanax as needed for anxiety/agitation with a start date of 06/06/2024. Physician's orders for Resident #88 included for staff to monitor for anti-anxiety side effects and targeted behavior with a start dates of 05/14/2024, and to monitor for anti-depressant side effects and targeted behavior with start dates of 05/15/2024. Record review of Resident #88's care plan dated 05/15/2024 reflected a focus for antidepressant medication use related to depression diagnosis. Further review revealed a focus for anti-anxiety medication use related to anxiety disorder dated 05/15/2024. During an interview LVN X she stated she was the MDS coordinator. She stated that if a resident was admitted with a diagnosis, it should have been indicated on section I of the MDS. LVN X stated that she read through the NP and psychology/psychiatry notes for any updated diagnosis to determine if the resident had a change or update to their diagnoses. LVN X stated that she also received information through meeting with the IDT. LVN X stated that the residents care plan and the MDS should match with accurate information. During an interview on 06/13/2024 at 2:15 PM, when asked if an MDS assessment accurately reflects a resident's status if admitting diagnosis are missing, the DON answered no. The DON answered yes when asked if information from residents' assessments should be accurately reflected on their care plan and MDS assessments. During an interview on 06/13/2024 at 2:46 PM, when asked if an MDS assessment accurately reflected a resident's status if admitting diagnoses are missing, the ADM answered no. The ADM answered yes when asked if information from residents' assessment should have been reflected on their care plan and MDS. During an interview on 06/13/2024 at 2:19 PM, the ADM stated that MDS does not have a related policy and the facility follows the RAI manual. Review of CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023, reflected the intent of Section I: Active Diagnosis was to code diseases that have a direct relationship to the resident's currents current functional status, cognitive status, mood or behavior status, medical treatments, and nursing monitoring. It also reflected that the MDS assessment was to provide an updated, accurate picture of the resident's current health status. Further review reflected to document active diagnoses on the MDS such as cancer and psychiatric/mood disorder.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interviews and record review, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness, developmental disability, or intellectual disability, were provided with a PASRR Level II assessment for 1 (Resident #86) of 3 residents reviewed. The facility failed to ensure Resident #86 received a PASRR level 2 evaluation. This failure could place residents at risk for not receiving necessary mental health services to reach their highest practicable level of well-being. Finding included: Record review of Resident #86's face sheet dated 6/12/2024 revealed an admitted [DATE] with diagnoses of unspecified fracture of left femur (traumatic injury to femur), acute respiratory failure (when one does not receive sufficient oxygen throughout the body), schizophrenia (a mental disorder characterized by disruptions in thought process), and bipolar disorder (serious mental illness that causes unusual shifts in mood). Record review of Resident #86's MDS assessment dated [DATE] revealed a BIMS score of 11 which indicated a moderate cognitive impairment. Section I of Resident's MDS reflected active diagnosis of bipolar disorder and schizophrenia. Record review of physician's orders for Resident #86 revealed an order for Seroquel indicated for Schizophrenia. Record review of Resident #86's care plan dated 4/13/2024 reflected that [Resident #86] is at risk for impaired thought processes [related to diagnoses of] schizophrenia/bipolar. Record review of Resident #86's PASRR Level 1 screening dated 4/12/2024 revealed no was selected under Section C read in part .is there evidence or an indicator this is an individual that has a mental illness? Record review of undated document titled Active Residents with PASRR Positive PE revealed Resident #86 was not listed. During an interview with LVN Won 6/13/2024 at 12:30 PM, LVN W reviewed PASRR Level 1 for Resident #86. LVN W stated that it indicated a negative (all questions indicated as no) on the PASRR level 1 but Resident #86 had a diagnosis of bipolar disorder. LVN W stated that with a diagnosis of bipolar disorder and schizophrenia, the PASRR level 1 should be positive. LVN W stated if the PASRR level 1 was incorrect upon a Resident's admission, staff should talk with the MD, and confirm the diagnoses. After admission and a diagnosis was confirmed by an MD, a correction form should have been submitted. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/2024 at 1:20 PM, LVN X stated that she was the MDS coordinator and responsible for the MDS assessments. LVN X stated that the MDS coordinator was also responsible for reviewing PASRR Level 1 screenings for new admissions. LVN X stated that if a resident had a diagnosis of schizophrenia or bipolar disorder without a diagnosis of dementia the PASRR level 1 should have been positive. LVN X stated that if PASRR level 1 was incorrect it should have been corrected via form 1012 after the diagnosis was confirmed by the MD. On 6/13/2024 at 2:11 PM, the DON stated that she has been the DON at the facility for five years. She stated that the facility's process for identifying residents with a possible mental illness, intellectual disability, or related condition prior to admission was reviewing the PASRR level 1 from the hospital, reviewing the resident's medical chart, and possible interview with the family. The DON stated that facility's MDS nurse notified staff if there was a newly identified diagnosis after admission and any changes made to care would have been relayed to the floor staff. The DON stated that the MDS nurse and social worker work together to make the referral to the appropriate state-designated authority when a resident was identified to have an evident or possible MD, ID, or related condition. On 6/13/2024 at 2:47 PM with the ADM, she stated that if a PASRR level 1 was not accurate it could result in a resident's needs potentially not being met. Review of undated document titled Policy: PASRR POLICY AND PROCEDURE reflected, The facility will designate an individual to follow up on ALL residents have received a PASRR Level I screening. If facility serves a resident with a positive PASRR Level I screening, the facility MUST have obtained A PASRR Level II evaluation from the Local Authority or have documented attempts to follow up with the Local Authority to obtain the PASRR Level II evaluation.

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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** 40884 Based on observations, interview, and record review the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for three of eight residents (Resident # 20, Resident #39, and Resident #72) reviewed for quality of life. 1. The facility failed to ensure Resident #20 and Resident #39's nails were cleaned. 2. The facility failed to ensure Resident #72's nails were cleaned and did not have rough edges. These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings included: 1. Record review of Resident #20's Face Sheet dated, 06/13/2024, revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses of need for assistance with personal care (providing care that is related to the patient's body, appearance, hygiene, and movement), lack of coordination (uncoordinated movement due to a muscle control problem that causes an inability to coordinate movements), muscle weakness (lack of muscle strength), and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). Record review of Resident #20's Quarterly MDS Assessment, dated 05/17/2024, reflected the resident had a BIMS score of 4 which indicated her cognitive status was severely impaired. Resident #20 was assessed to require assistance with personal hygiene, dressing, showers, toileting, oral hygiene, and transfers. Resident #20 did not refuse care. Record review of Resident #20's Comprehensive Care Plan, dated 05/02/2024 reflected Resident #20 was at risk for impaired cognitive function or thought process. Intervention: give step by step instructions on at a time as needed to support cognitive function. Resident #20 had ADL self-care performance deficit related to impaired mobility and weakness. Intervention: Bathing- check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Observation on 06/11/2024 at 9:57 AM Resident #20 was in her room sitting in her wheelchair and watching television. Resident had blackish substance underneath all her fingernails on her right hand. Resident #20 was not interviewable. Record review of Resident #39's Face Sheet dated, 06/13/2024, reflected a [AGE] year-old male admitted to the facility with diagnoses of: lack of coordination (uncoordinated movement due to a muscle control problem that causes an inability to coordinate movements), generalized muscle weakness (lack of muscle strength), and malaise (general feeling of discomfort, illness, or lack of well-being). (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 Resident #39's Quarterly MDS Assessment, dated 05/07/2024, reflected Resident #39 had a BIMS score of 8 which indicated Resident #39's cognition was moderately impaired. Resident #39 did not reject care. He required assistance with ADLs such as: personal hygiene, dressing, showers, toileting, and transfers. Record review of Resident #39's Comprehensive Care Plan, dated 05/22/2024, reflected Resident #39 had ADL self-care performance deficit related to impaired mobility. Intervention: Resident required assistance with bathing and dressing. Observation on 06/11/2024 at 10:07 AM Resident #39 was lying in bed in his room. He had hard thick blackish substance underneath his middle, index, and fore fingernails on his right hand. Interview on 06/11/2024 at 10:10 AM Resident # 39 stated he asked someone who worked there two times if someone would clean his nails. He stated it was approximately two days ago. Resident #39 stated that after he asked the same person twice to clean his nails, she stated she would do it later in the day, and he did not see her anymore that day. He stated he did not ask anyone else. Resident #39 stated he would clean his nails himself, but he was not able to do this by himself. 2. Record review of Resident #72's Face Sheet, dated 06/13/2024 reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of muscle weakness (lack of muscle strength), unspecified lack of coordination (uncoordinated movement due to a muscle control problem that causes an inability to coordinate movements), type 2 diabetes mellitus without complications (a condition that happens because of a problem with the way the body regulates and uses sugar as fuel), and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (loss of partial or total body function on one side of the body, whereas hemiparesis is characterized by one sided weakness, but without complete paralysis). Record review of Resident #72's Quarterly MDS Assessment, dated 05/01/2024, reflected Resident #72 had a BIMS score of a 4 indicated his cognition was severely impaired. Resident #72 did not reject care. Resident #72 required assistance with eating, toileting, shower, dressing, personal hygiene, and transfers. Record review of Resident #72's Comprehensive Care Plan, dated 05/11/2024, reflected Resident #72 had diabetes mellitus. Intervention: Resident #72's nails should always be cut straight across, and never cut corners. Resident #72's rough edges of the nails should be filed with emery board. Resident #72 had ADL self-care performance deficit. Intervention: He required assistance with personal hygiene, skin inspection, and bathing. Observation on 06/11/24 at 11:18 AM Resident #72 was lying in bed. The tip of Resident #72's nails were not trimmed evenly on his right and left hands. Resident #72 had a blackish substance underneath his nails on his forefinger, middle finger, and index finger on his right hand. In an interview on 06/11/2024 at 11:22 AM Resident #72 stated he wished someone would do something with his nails. He stated his nails were dirty. Resident #72 did not respond verbally or with gestures when asked if he requested his nails to be cleaned and /or filed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/13/24 11:20 AM. RN A stated the nurses and CNAs were responsible for nail care. He stated the nurses were responsible to clean, trim, and file all resident's nails with a diagnosis of diabetes. RN A also stated it was the CNA's responsibility to trim, clean, and file all other residents' nails. He stated the CNAs usually completed nail care during the residents' showers or as needed. He stated the blackish substance possibility could possibly be feces or any type of bacteria underneath the resident's nails. RN A stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as diarrhea or vomiting. He also stated a resident may become dehydrated. RN A stated he had been in- serviced on nail care- cleaning, filing, and trimming residents' nails. RN A stated if a resident's nails were not smooth and was rough around the edges there was a possibility the resident may scratch themselves and develop a skin tear. He stated he was not aware of Resident #39, Resident #20, or Resident #72 refusing nail care. He stated he was assigned to be their nurse numerous times. RN A stated he had been an employee at the facility approximately 1 year. In an interview on 06/13/24 at 11:50 AM, CNA C stated the CNAs were responsible for nail care unless a resident was a diabetic. She stated the CNAs usually cleaned, cut, and filed residents' nails during showers or as needed. CNA C stated the nursing staff were expected to clean and trim residents' nails immediately if there was a blackish substance underneath the residents' nails, and trim or file if the nail was not smooth. She stated the blackish substance may be bacteria from feces underneath the residents' nails. CNA C stated if a resident swallowed the blackish substance there was a possibility a resident may become ill with stomach issues or any type of intestinal issues. She stated there was a possibility a resident may need to be assessed at the emergency room if they became severely ill. CNA C stated if a resident's nails were not smooth and was rough on top of the nail, there was a possibility the resident may scratch their hand, arm, or face. She also stated it was a possibility the resident may cause a skin tear on themselves or another resident if they accidentally scratched another resident's hand. CNA C stated she was assigned care to Resident #72, Resident #20, and Resident #39 and from her knowledge these residents did not refuse nail care. She stated she had given nail care to all three of these residents and did not recall how many times. She stated she had been in-serviced and trained on nail care but did not remember the dates of the in-service. In an interview on 06/13/24 at 12:05 PM, CNA D stated she would report to a nurse if a resident with diagnosis of diabetes needed any type of nail care such as: cut, cleaned, or filed. She stated the CNAs were responsible for all other resident's nail care such as cleaning, trimming, and filing the nails. She stated nail care was usually completed during showers or as needed. CNA D stated nail care was to be completed daily if a resident's nails were dirty. She also stated if a resident had a blackish substance underneath their nails, it could be any type of germs. She stated there was a possibility a resident may eat with their hands and the blackish substance may transfer from residents' hands to the food. She stated the resident may develop stomach problems such as nausea and vomiting. She stated it was a possibility a resident may need to be assessed at a hospital if it was severe. CNA D stated if a residents' nails were rough there was a possibility a resident may scratch themselves and develop a skin tear or could scratch any part of their body and cause some type of skin infection. She also stated she had been in- serviced to clean and trim residents' nails in the shower and/or as needed except for diabetic nails. CNA D also stated she did not recall when the last in-service on nail care was given by nurse supervisors. She stated she had given care to Resident #20, Resident #39, and Resident #72 and she was not aware of them refusing nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/13/24 at 12:20 PM, the Director of Nurses stated if a resident had dirty nails such as a blackish substance there was a possibility of bacteria on their fingers and/or underneath the resident's nails. She stated there was a potential a resident could ingest bacteria from their fingernails into their mouth. The Director of Nurses stated it depended on the type of bacteria of what type of illness a resident could receive from the bacteria. She stated a resident potentially could become ill with stomach issues or any type of infection. The Director of Nurses stated a resident had a potential to scratch themselves and may develop a skin concern such as a skin tear and may develop an infection if the residents' nails were not trimmed properly. The Director of Nurses stated it was the nurse supervisor's responsibility to monitor nursing staff to ensure residents were receiving proper nail care. She stated the CNA's or Nurses were responsible to cut, trim, and clean residents' nails. She stated the nurses were responsible for the residents with a diagnosis of diabetes. She stated the staff were required to trim, cut, and clean nails during their showers and as needed. In an interview on 06/13/2024 at 12:35 PM, the Administrator stated the CNAs were responsible for nail care during the residents' showers and as needed except for the residents with a diagnosis of diabetes. She stated the nurses performed all fingernail care for the diabetic residents. The Administrator also stated if a resident swallowed any type of blackish substance and it was determined to be bacteria, there was a potential a resident may become ill with a stomach infection. She also stated the resident may have symptoms such as diarrhea and vomiting. She stated it was the nurse supervisor's responsibility to monitor nail care. The Administrator stated there was a potential for a skin tear if a resident's nails were not smooth and the resident scratched themselves anywhere on the body. Record review of the Facility's Policy on Quality of Care (ADL, Services to carry out), reviewed 01/2024 reflected, It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. Procedures: 1. If a resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene will be provided by qualified staff. 2. Bathing will be offered at least weekly, and PRN per resident request. 3. Residents will be involved in decision making and given choices related to ADL activities as much as possible.

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	676459	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sedona Trace Health and Wellness Center	8324 Cameron Road Austin, TX 78754

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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** 47065 Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart and ensure infection control measures during implementation of care, handling, cleaning, storage and disposal of equipment, supplies, biohazardous waste and including infection control practices for mechanical ventilation/tracheostomy care including the use of humidifiers were followed by staff for 3 (Residents #5, #36, and #77) of 7 residents reviewed for respiratory care, in that: The facility failed to ensure Resident #5, #36 and #77's nasal cannulas and tubing were properly stored when not in use. This deficient practice could place residents at risk of cross-contamination and illness. Findings included: Record review of Resident #5's Admission Record, dated 06/13/24, reflected an [AGE] year-old female who was admitted to the facility on [DATE], readmitted [DATE], and diagnoses including: unspecified dementia, unspecified Alzheimer's disease, acute respiratory failure with hypoxia, need for assistance with personal care, and cognitive communication deficit. Record review of Resident #5's Comprehensive MDS Assessment, dated 05/12/24, revealed Resident #5 had a BIMS score of 2, which indicated she had severe cognitive impairment. Resident #5 also required oxygen therapy. Record review of Resident #5's Order Summary Report, dated 06/09/24, revealed Resident #5 had an order for Oxygen 1 lpm via simple mask or nasal canula PRN if tolerated by her that was ordered on 05/09/24. There was no start date. Record review of Resident #5's MAR for May and June 2024 revealed Resident #5 did not receive any of her order for Oxygen 1 lpm via simple mask or nasal canula PRN if tolerated by her from 05/09/24 through 06/14/24. Record review of Resident #36's Admission Record, dated 06/13/24, revealed an [AGE] year-old male who was admitted to the facility on [DATE] and diagnoses including: unspecified dementia, cognitive communication deficit, Alzheimer's disease with late onset, need for assistance with personal care, and dementia in other diseases classified elsewhere. Record review of Resident #36's Quarterly MDS Assessment, dated 04/25/24, revealed Resident #36 had a BIMS score of 11, which indicated he had moderate cognitive impairment. Record review of Resident #36's Order Summary Report, dated 06/13/24, revealed Resident #36 had an order for PRN oxygen 3l/min via nasal cannula with oxygen <90% every 8 hours as needed for SOB that was ordered and started on 06/09/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #36's MAR for June 2024 revealed Resident #36 had his PRN oxygen 3l/min via nasal cannula with oxygen <90% every 8 hours as needed for SOB last administered on 06/10/24 at 6:59 A. M. Record review of Resident #77's Admission Record, dated 06/13/24, revealed she was a [AGE] year-old female who was admitted on [DATE], readmitted on [DATE], and diagnoses including: unspecified asthma with acute exacerbation, unspecified down syndrome, unspecified psychosis, shortness of breath, and cognitive communication deficit. Record review of Resident #77's Quarterly MDS Assessment, dated 05/20/24, revealed Resident #77 had a BIMS score of 2, which indicated she had severe cognitive impairment. Resident #77 also required oxygen therapy. Record review of Resident #77's Order Summary Report, dated 06/13/24, revealed Resident #77 had an order for change nebulizer tubing/mask/mouthpiece every night shift every Sunday for change tubing/mask that was ordered on 05/17/24 and started on 05/19/24, change O2 tubing and humidifier bottle every night shift every Sunday for change tubing ordered on 05/17/24 and started on 05/19/24, and O2 at 2 L/MIN via NC as needed for SOB, respiratory distress, cyanosis and labored breathing ordered and started on 05/17/24. Record review of Resident #77's MAR for May and June 2024 revealed Resident #77 had his nebulizer/tubing/mask/mouthpiece and O2 tubing last changed on 06/09/24. Resident #77 did not have O2 at 2 L/MIN via NC as needed for SOB, respiratory distress, cyanosis (Bluish or grayish color of the skin, nails, lips, or around the eyes) and labored breathing administered in May and June 2024. An observation of Resident #5's room on 06/11/24 at 9:02 A.M. revealed there was tubing and nasal cannula that were sitting on the top of her bedside table. An observation of Resident #77's room on 06/11/24 at 11:06 A.M. revealed the oxygen tank attached to the back of her wheelchair was not on. Resident #77 was wearing the tubing and nasal cannula attached to the oxygen tank. There was oxygen tubing that sat on top of the dresser that was across Resident #77's bed. There was also an oxygen machine in front of Resident #77's recliner that was next to the bed and not on. There was tubing and nasal cannula that were attached to the machine and sitting on the recliner. During an interview on 06/11/24 at 11:06 A.M., Resident #77 stated staff did not check on her, did not bag her tubing and nasal cannula sitting on her dresser and recliner chair and she last used her oxygen machine 20 minutes ago. An observation of Resident #36's room on 06/11/24 at 2:55 P.M. revealed there was a nasal cannula and tubing sitting on Resident #36's bedside table that was next to his bed. During an interview on 06/11/24 at 2:55 P.M., Resident #36 stated he did not know when he last used his oxygen machine, staff checked on him, and he had no concerns or issues. During an interview on 06/13/24 9:50 A.M., Administrator stated the facility did not have a policy on oxygen tubing and nasal cannula storage when oxygen machine and tanks were not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/24 at 1:00 P.M., RN A stated she was trained on respiratory care and in-serviced by the ADON monthly. RN A stated if the oxygen machine was not in use, nurses were to bag tubing in a plastic bag with dates and a label. RN A also stated residents' health could be at risk if the oxygen tubing and nasal cannula was not bagged when the oxygen machine was not in use. RN A stated the DOR, ADON, and MS people round in the morning and ensure oxygen tubing and nasal cannula was stored away when not in use. RN A stated she also rounded every morning and mid-afternoon during her 8-hour shifts. RN A stated she did not know Residents #5, 36, and 77's tubing and nasal cannula were not stored away when their oxygen therapy was not in use. During an interview on 06/13/24 at 1:13 P.M., LVN L stated he was last trained on respiratory care online in October 2023. LVN L stated it had been a while since he had that training provided to him. LVN L also stated he was trained on how to follow oxygen orders and perform respiratory therapy. LVN L stated staff were supposed to look at the condition of oxygen machines weekly. LVN L also stated the oxygen tubing, concentrators, and water bottles were to be checked and changed weekly. LVN L stated nurses were to bag tubing and nasal cannula. LVN L also stated tubing and nasal cannula needed to be in a container or bag to prevent it from pathogens when the oxygen machine or tank not in use. LVN L explained if nasal cannula was lying on a resident's bed, he would inspect the tubing, use nursing judgment, discard the tubing, replace the tubing, bag the new tubing, date the bag, ensure tubing condition was good, notify a nurse if tubing was not in use and lying on bed, and document in progress notes. LVN L stated residents' health could be at risk if tubing and nasal cannula were not bagged when oxygen therapy was not in use because it was a respiratory risk. LVN L also stated he did not know Residents #5, 36, and 77's tubing and nasal cannula were not stored away when their oxygen therapy was not in use. During an interview on 06/13/24 at 1:28 P.M., CNA E stated she was trained and in-serviced by the ADON on rounding and ADL care. CNA E also stated she rounded (checked on residents) every hour. CNA E also stated CNAs and nurses bagged tubing and nasal cannula when oxygen therapy was not in use. CNA E stated Residents could affect health if tubing not bagged because of airborne pathogens and water could get in tubing. CNA E also stated she did not know Residents #5, 36, and 77's tubing and nasal cannula were not stored away when their oxygen therapy was not in use. During an interview on 06/13/24 1:37 P.M., CNA H stated she was trained and in-serviced by the ADON on ADL care and rounding. CNA Hstated she rounded on residents every two hours during her 8-hour shift. CNA Halso stated would notify a nurse if a residents' oxygen tubing and nasal cannula was sitting on the bed when the oxygen machine was not in use. CNA Hstated nurses bagged oxygen tubing and nasal cannula. CNA Halso stated residents could get an infection or develop bacteria if oxygen tubing and nasal cannula were on the ground and not bagged when oxygen therapy was not in use. CNA Hstated she did not know Residents #5, 36, and 77's tubing and nasal cannula were not stored away when their oxygen therapy was not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/13/24 01:58 PM During an interview, ADON revealed she was trained and in-serviced on respiratory care by the facility annually. ADON stated the facility faxed reeducation to staff annually. ADON also stated that she was taught to bag and date oxygen tubing and nasal cannula if the oxygen therapy was not in use. ADON stated the nurses bag residents' oxygen tubing and nasal cannula. ADON also stated she told the CNAs to be mindful and bag the oxygen tubing and nasal cannula when not in use. ADON stated the Director of Nurses, Treatment Nurse, SW, and Dietary department conducted room checks every morning to ensure no issues with care, such as respiratory care and she was trained report to the Administrator of any findings. ADON also stated residents' health could be affected if oxygen tubing and nasal cannula was lying out on the floor when the oxygen machine was not in use because could it cause an infection. ADON stated she did not know Residents #5, 36, and 77's tubing and nasal cannula were not stored away when their oxygen therapy was not in use and that oxygen tubing should have been bagged up. During an interview on 06/13/24 2:10 P.M., Director of Nurses revealed she was trained on respiratory care annually and as needed. Director of Nurses stated she learned to store oxygen tubing and nasal cannula in bags and change the tubing and nasal cannula weekly. Director of Nurses also stated she taught staff same practice on hire and reeducated staff PRN. Director of Nurses stated there were guardian angel rounds that were done daily to ensure tubing and nasal cannula were bagged. Director of Nurses also stated CNAs and nurses can bag tubing and nasal cannula. Director of Nurses stated residents could be at risk for an infection if the oxygen tubing and nasal cannula were not bagged. Director of Nurses also stated she was not aware Residents #5, 36, and 77's oxygen tubing and nasal cannula were not bagged and did not know why they were not bagged. Director of Nurses stated staff rounds every two hours and as needed. Record review of the facility's Oxygen Administration (Mask, Cannula, Catheter) policy and procedure, undated, revealed there were no procedures related to who, when, where, and how oxygen tubing and nasal cannula were to be stored when oxygen machine or tank was not in use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safely for 1 of 1 kitchen reviewed for food storage and sanitation, in that: 1. The facility failed to ensure kitchen staff secured their hair in hairnets in the kitchen. 2. The facility failed to clean the inside of the one ice machine. 3. The facility failed to discard expired food and beverage items in the walk-in refrigerator. 4. The facility failed to ensure the freezer unit in the walk-in freezer was maintained in safe operating condition . These deficient practices could place residents at risk of foodborne illness. Findings included: An observation of the kitchen on [DATE] 9:12 A.M. revealed [NAME] G's hairnet was sitting on top of her head. The hairnet covered the top half of [NAME] G's hair, leaving the bottom half not protected or covered. An observation of the ice machine on [DATE] at 9:17 A.M. revealed there were black spots on the top ceiling inside the ice machine. An observation and interview of CNA H at the ice machine [DATE] on 9:19 A.M. revealed she was scooping ice from the ice machine into two ice chests sitting on carts. CNA H revealed stated there were three ice chests for the entire facility that staff use to provide residents with ice water. CNA H stated there was one ice chest per hallway. An observation of the walk-in refrigerator on [DATE] at 9:22 A.M. revealed revealed there was an opened gallon jar of mayonnaise with an expiration date of [DATE], an opened gallon jar of Caesar salad dressing with an expiration date of [DATE], an opened gallon jar of ranch salad dressing with an expiration date of [DATE], and an opened gallon of lime juice with an expiration date of [DATE]. An observation of the walk-in freezer on [DATE] at 9:27 A.M. revealed revealed there was a build-up of ice on the bottom of the freezer unit mounted to the ceiling. There were two boxes of dark meat that were stacked on top of each other and sitting on the shelf just below the freezer unit, soaked on one side of the box base, and bending. An observation of the kitchen on [DATE] 12:12 P.M. revealed DA I was standing in front of the meal service station. DA I had her hair net covering the top half of her head, leaving the bottom half not covered or protected. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the dietary cleaning schedule revealed there was no scheduled maintenance days for the cleaning the inside of the ice machine and freezer unit. There were also no scheduled maintenance days for checking food and beverage items in the walk-in freezer and refrigerator. An observation on [DATE] at 12:13 P.M. revealed DA I walked to the food preparation area and rearranged her hair net to cover all her hair. An observation of the ice machine on [DATE] at 9:09 A.M. revealed there were black spots on the top ceiling inside the ice machine. During an interview on [DATE] at 9:24 A.M., DM revealed the ice buildup on the freezer unit was not from the freezer unit. DM stated the buildup of ice on the bottom of the freezer unit in the walk-in freezer occurred because the kitchen staff were not securely closing the walk-in freezer door at the beginning of [DATE]. DM stated she had maintenance install a latch on the walk-in freezer door and trained staff on how to secure the latch. DM stated her and the kitchen staff have not had any issues after maintenance installed the door latch and she trained staff on how to secure the door with the latch. DM also stated she discarded food and beverage items stored in the refrigerators daily based on the best by date labeled on the product and checked the walk-in freezer unit daily. DM stated she did not have logs or documentation reflecting that she was checking and discarding expired food and beverage items from the refrigerator and freezer and that she was checking the freezer unit in the walk-in freezer . DM stated she did not know there were expired food items in walk-in refrigerator. DM also stated residents could be at risk of becoming sick if they ate meals prepared with expired food. An observation of the walk-in refrigerator on [DATE] at 9:28 A.M. revealed two-gallon jars of ranch dressing with expiration dates of [DATE] and [DATE], one opened gallon jar of Caesar dressing with expiration date of [DATE], one opened gallon jar of mayonnaise with an expiration date of [DATE], and one opened gallon of lime juice with an expiration date of [DATE]. An observation of the ice machine on [DATE] at 9:50 A.M. revealed there were black spots on the inner ceiling inside the ice machine. The DM observed the black spots on the inner ceiling inside the ice machine. During an interview on [DATE] at 9:50 A.M., DM revealed there were no ice machine maintenance records from the kitchen. DM explained the MS drained and cleaned the inside of the ice machine every quarter. DM stated MS might have a policy on ice machine draining and interior maintenance. DM stated she cleaned the exterior and scooper of the ice machine. DM stated the ice machine exterior and scooper were cleaned weekly. During an interview on [DATE] at 9:51 A.M., DM revealed there were no cleaning sheets for the freezer unit. DM stated she conducted daily rounds on the freezer unit. DM stated there was no policy on cleaning the freezer unit. During an interview on [DATE] at 9:56 A.M., DM revealed there was no policy on food storage and discarding food. DM stated staff were required to wear hairnets, at all times in the kitchen. DM also stated she observed and instructed [NAME] G about her hair net not being properly placed on her head covering all her hair, but she did not know about DA I was not wearing a hair net properly as well. DM stated the facility followed the TFER on hair net policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews with two DAs and two Cooks in the kitchen on [DATE] at 10:43 A.M., the kitchen staff revealed they all knew they needed to wear a hair net at all times when in the kitchen and all hair should be covered. Attempted interview with DA I on [DATE] at 11:44 A.M., via telephone. Left a voicemail and call back number. DA I never returned the call prior to exit. During an interview on [DATE] at 11:59 A.M., [NAME] G revealed that she received training on proper hair restraints and kitchen duties. [NAME] G stated that proper hair restraint would be to have all hair covered by the hair net. [NAME] G also stated that she was told to put her hair in a ponytail and then put it in the hairnet. [NAME] G stated her problem was that she has very long hair with deadlocks. [NAME] G described that she would have to wrap her hair in a ponytail 8 times and then she put the hair net on. [NAME] G stated people think that she did not have a hair net on because her deadlocks are extremely long and fray like. [NAME] G also stated that there was concern for cross contamination and hair getting into the food, which can make the residents sick, if proper hair restraints were not used. When asked why she was observed without proper hair restraints, [NAME] G stated, I try to do my best to keep it wrapped up or I'll have to find a new job. [NAME] G asked what she can do and stated that the DM told her to ask for help if she was not able to get all her hair in the hairnet. [NAME] G stated she had to ask for help with using a hair net to cover all her hair. Record review of the facility's kitchen quarterly work history report revealed MS checked filters, cleaned coils, sanitized interior, and delimed as necessary on the ice machines and ice bins chests last on [DATE]. Record review of the TFER provided by the DM on [DATE] at 12:24 P.M. revealed the following: Food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers the body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on observations, interviews, and record reviews, the facility failed to adequately equip to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member to a centralized staff work area for 2 (Resident #34 and 48) of 6 residents reviewed for call lights, in that: The facility failed to ensure Residents #34 and 48's bathroom and shower call lights operated on 06/11/24. An IJ was identified on 06/11/24. The IJ template was provided to the facility on [DATE] at 7:32 P.M. While the IJ was removed on 06/13/24, the facility remained out of compliance at a scope of isolated and a severity level of actual harm that is not immediate jeopardy because of the facility need to evaluate the effectiveness of its corrective actions. This failure could place residents at risk for injury, accidents, not having needs met, and death. Findings included: Record review of Resident #34's Admission Record, dated 06/11/24, revealed an [AGE] year-old female who was admitted on [DATE], 02/28/23 , and diagnoses including : cerebral infarction, vascular dementia, urgency of urination, pain in unspecified joint and left elbow, other abnormalities of gait and mobility, cognitive communication deficit, difficulty in walking, unsteadiness on feet, generalized muscle weakness, other lack of coordination, other reduced mobility, and need for assistance with personal care. Record review of Resident #34's Quarterly MDS Assessment, dated 04/11/24, revealed Resident #34 had a BIMS score of 15, which indicated she was cognitively intact. Resident #34 also required partial/moderate assistance with toileting and showering. Record review of Resident #34's Care Plan, dated 05/02/24, revealed Resident #34 had ADL self-care performance deficit and required staff participation to use toilet and with bathing. Record review of Resident #48's Admission Record, dated 06/12/24, revealed a [AGE] year-old female who was admitted on [DATE], readmitted [DATE], and diagnoses including: unspecified dementia, other lack of coordination, generalized muscle weakness, unspecified Alzheimer's disease, muscle wasting and atrophy, other abnormalities of gait and mobility, unsteadiness on feet, and cognitive communication deficit. Record review of Resident #48's Comprehensive MDS Assessment, dated 05/03/24, revealed Resident #48 had a BIMS score of 1, which indicated she had severe cognitive impairment. Resident #48 also was dependent on toileting and showering. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #48's Care Plan, dated 05/08/24, revealed Resident #48 had ADL self-care performance deficit and required one staff participation to use the toilet and bathe/shower three days a week and as necessary. An observation and interview of Resident #34's bathroom on 06/11/24 at 10:30 A.M. revealed the emergency call light next to the toilet did not work. Resident #34 revealed the call light in her bathroom was not working. Resident #34 stated the bed call light was currently working, but the call light had stopped working about one month ago. An observation of Resident #48 on 06/11/24 at 3:16 P.M. revealed she was sitting on the toilet in the bathroom. Resident #48's RP was standing next to her. During an interview on 06/11/24 at 3:21 P.M., Resident #48's RP revealed she was Resident #48's POA. RP stated the emergency call light in Resident #48's shower area does not work and had been broken for one month. RP explained she informed a CNA, day shift nurse and MS. RP went on to explain MS attempted to repair the emergency call light, but it was still broken. RP stated she visited Resident #48 daily for at least 5 hours a day. RP explained she helped Resident #48 go to the toilet and other tasks because Resident #48 was blind. RP stated Resident #48 required assistance with all ADLs due to her blindness and Alzheimer's disease. RP stated Resident #48 was not able to use the call light because she was blind, could not see the call light, and did not have the cognitive capacity to know how to use it. RP explained the ADON told her that the nurses checked on residents every two hours and knew this was not done mostly during night shift because she had electronic monitoring in place in Resident #48's room. An observation and interview of Resident #48's bathroom on 06/11/24 at 4:00 P.M. revealed the call light next to the toilet and in the shower did not work. Resident #48's RP revealed Resident #1's emergency call light next to the toilet also did not work and they reported to staff. An observation of the call light testing system on 06/11/24 at 4:39 P.M. revealed Resident #34's and Resident #48's call lights did not populate as inoperable in the call light testing system. During an interview on 06/11/24 at 4:39 P.M., MS revealed he tested residents' call lights. MS stated he had an issue with call lights in residents' rooms. MS explained this issue had been ongoing for the last six months. MS also stated he had been resetting call lights to troubleshoot the issue. MS stated residents' shower and toilet emergency call lights should be working. MS also stated there was one call light he needed to troubleshoot and one call light he resolved 1-2 months ago. MS explained the call light company the facility used had changed one month ago. MS stated he tested call lights once monthly. MS also stated he pulled status reports at the call light box located at the nursing stations to determine which call lights were not working. MS stated he logged call light testing. MS also stated he installed doorbells for dependent and severely cognitively impaired residents. MS stated residents' health or safety could be affected if their call lights did not work. An observation of Resident #48's bathroom on 06/11/24 at 4:43 P.M. revealed MS tested the toilet and shower call light, and it did not work. An observation and interview of Resident #34's bathroom on 06/11/24 at 4:48 P.M. revealed MS tested the toilet and shower call light, and it did not work. MS stated, Oh that's not working. (continued on next page)

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	676459	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sedona Trace Health and Wellness Center	8324 Cameron Road Austin, TX 78754

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/11/24 at 4:49 P.M., MS stated Resident #48's call light had been having issues since 04/29/24, he tested Resident #48's call light on 04/29/24, he has not tested residents' call lights in June 2024, and the call light company last came out to troubleshoot call lights on Resident #48's and 34's hallways on 06/04/24. During an interview on 06/11/24 at 5:00 P.M., CNA M revealed she was not aware of any call lights that were not working at the time of the interview. CNA M stated residents' call lights were all working. When asked if she was made aware of a call light not working, CNA M stated she would tell MS or the nurse. CNA M also stated that she checked on residents every 30 mins. During an interview on 06/11/24 at 5:04 P.M., MA N revealed she was not aware of any call lights that were not working at the time of the interview. During an interview with Administrator on 06/11/24 at 5:04 P.M., Administrator revealed a call light company came to the facility last week (06/04/24) to repair call light system. Administrator stated she did not know how many residents' call lights were repaired. Administrator also stated the facility had 2-3 residents' call lights continuously not working. Administrator explained residents probably went a few days without call lights not working. Administrator stated she did not know how long call lights were not working in residents' rooms and bathrooms and that she would need to get with the MS to find out. Administrator also stated if the call lights were not working at night, then the staff would call the MS or herself. Administrator stated there had been issues with the call lights every now and then, but she did not know how long there had been problems with residents' call lights not working in residents' rooms or bathrooms. Administrator also stated the call light status report system did not show residents whose call lights were not working when MS tested the system on 06/11/24. Administrator stated she was not aware call light status report showed no results of residents' call lights not working despite there being results in the past. During an interview on 06/11/24 at 5:05 P.M., LVN O revealed all residents' call lights on the hall Resident #48 resided on were working at the time of the interview . LVN O stated that if she was made aware of a call light that was not working, there was an email she could send, and she would let maintenance know. LVN O also stated that they have call bells they can provide the residents and then they would check on the resident every hour. LVN O stated that no residents had a call bell at the time of the interview that she was aware of. During an interview on 06/11/24 at 5:05 P.M., CNA P revealed she was assigned to 12 rooms on the hallway Resident #34 resided on. CNA P stated all residents' call lights were working okay at the time of the interview. CNA P also stated when there were issues with call lights, staff were trained to notify Maintenance through a work order system. CNA P stated when call lights were not working, staff provided residents with call bells. CNA P also stated resident rounds were conducted every 30 minutes. During an interview on 06/11/24 at 5:10 P.M., RN Q revealed there were resident call light issues one week ago. RN Q explained when call lights were inoperable, the residents used call bells. RN Q stated she checked on residents every 30 minutes if residents could not use the call bell. RN Q also stated she received training on call lights. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Director of Nurses on 06/11/24 at 5:10 P.M., Director of Nurses revealed she would come to the facility and educate the staff on using call bells instead of call lights and increasing on making rounds for residents whose call lights did not work. Director of Nurses stated she would educate staff to be near residents' rooms due to being able to hear call bells if their call light did not work. Director of Nurses also stated if she did in-service staff on what to do when the residents' call lights were not working, then it would be in the facility's in-service book. During an interview on 06/11/24 at 5:22 P.M., CMA R revealed there were issues with residents' call lights. CMA R explained residents' call lights did not work when it rained. CMA R stated the residents have call bells in their rooms that they rang when they needed assistance. CMA R also stated she checked on the residents every 1-2 hours, and there was always someone available in the hallway. CMA R stated she has received in-servicing on call lights. Attempted to contact CNA J on 06/11/24 at 6:40 P.M. Left a voicemail and call back number. CNA J did not return the call prior to exit. Attempted to contact CMA K on 06/11/24 at 6:42 P.M. Left a voicemail and call back number. CMA K did not return the call prior to exit. During an interview on 06/11/24 at 6:43 P.M., RN A revealed all of the call lights were working on her shift today (06/11/24) on the hall Resident #48 resided on. RN A stated that if she became aware the call lights were not working, she would usually provide small bells for residents to use until their call lights were repaired. RN A also stated there were some call lights not working about two weeks ago and it was about three residents' rooms. RN A stated Resident #48's call light in her room was not working during that time. RN A also stated staff would increase rounds on those residents whose call lights were not working to make sure their needs were met. During an interview on 06/11/24 at 6:45 P.M., CNA H revealed she was trained on accidents, rounding, and call lights. CNA H stated she had not been in-serviced on call lights. CNA H also stated she would report to a nurse, MS or both if a resident's room call light did not work. CNA H stated one residents' room call light did not work a few days ago on the hallway Resident #34 resided on. CNA H also stated she learned this information when she came back to work (she did not know when, but believed it was a few days ago and did not know who told her). CNA H stated she gave the resident a little bell and tried to fix the call light as soon as possible according to the Director of Nurses on a specific day she could not remember. CNA H also stated residents' room, shower, and toilet call lights were working good today (06/11/24) that she noticed on the hall Resident #34 resided on. CNA H stated residents health and safety could be affected if their call lights did not work because they could hurt themselves and residents would not be able to get help. CNA H stated she was not aware Resident #34's bathroom call light was not working today (06/11/24). CNA H stated she checked on residents every 30 minutes. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of MS's Call Light Logbook Report, from 06/30/23 through 05/31/24, revealed MS documented on 05/31/24 that half of Resident #34's call lights in the room were inoperable and scheduled a technician to visit the facility on 06/03/24 to repair the call lights. MS documented on 04/30/24 that bathroom and call lights were inoperable in one resident room who resided on the same hallway as Resident #34 and three resident rooms who resided on the same hallway as Resident #48, who was one of the three rooms with inoperable call lights. MS documented on 03/31/24 that he was having problems with two resident rooms on the same hallway as Resident #34, who was one of the two rooms with inoperable call lights. Record Review of Work Order Report log, dated 12/11/2023 through 06/11/2024, revealed 31 different complaints of residents' call lights not working. Record review of the facility's Call Light Company work order, dated 05/03/24, revealed they troubleshooted and repaired the nurse call system on all four halls. Record review of the facility's Call Light Company work order, dated 05/13/24, revealed they made some repairs on the hallway Resident #34 resided on. Record review of the facility's Call Light Company work order, dated 05/23/24, revealed MS showed them that half of Resident #34's hallway had call lights that were not working. The company troubleshooted the system, found a bad cord shorting the system, replaced the cord, and system went back to normal. Record review of the facility's Call Light Company work order, dated 06/04/24, revealed they found that the nurse call station was down due to power overload. They also found some bad nurse cords, replaced them, advised the facility that they needed to order more, made some programming adjustments, tested the system, and everything worked as it should. Record review of the Staff In-Services for the past 3 months revealed staff were trained on call lights on 05/20/24 by unknown. The training covered having the call lights within reach and answering call lights in a timely manner . There were 9 staff members who attended the training. Record review of the facility's Call Lights policy and procedure revealed if the call light/bell was defective, staff were required to report the information to the unit supervisor. Record review of the facility's Accident Intervention policy and procedure's Accident Prevention and Safety section revealed staff were required to report call lights that did not work. This failure resulted in the identification of an IJ on 06/11/24. The Administrator was notified and provided with the IJ template on 06/11/24 at 7:32 P.M. The following Plan of Removal was submitted by the facility and accepted on 06/13/24 at 4:15 P.M.: Facility Plan of Removal Version 1 (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident Call System Per the information provided in the IJ Template given on 06/11/24, the facility failed to adequately equip to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from [Resident #48's and #34's] toileting and bathing facilities. Immediate Action 1. The Medical Director was notified on IJ on 06/11/24 at 9:00 P.M. by DON. 2. [Resident #48 and #34] refused to move rooms with functioning call systems. Care plans updated on both residents reflecting resident preference by MDS nurse. 1:1 will be provided for [Resident #48 and #34] until call lights are fixed and functioning. DON or designee will ensure 1:1 coverage is scheduled and is reflected on staffing sheet. Staff member responsible for 1:1 will utilize floor staff for break coverage. Staff member responsible for break coverage will be reflected on the staffing sheet. 3. All rooms were assessed to ensure call light system was working on 06/11/24 by interdisciplinary team to include [MS], [DOR], [ADON], and Assistant Business Office Manager. 4. Vendor for call system was called on 06/11/24 and will be at facility on 06/12/24 to address concerns in [Resident #48 and #34's room]. Results of assessment showed two additional rest rooms affected, both residents moved to rooms with functional call lights on 06/11/24. 5. In-services conducted with all staff on proper procedure of notifying leadership when call light system fails and how to educate residents/staff on using bells for communicating and identification of rooms with non-functioning call system on 06/11/24 by [Administrator] who was in serviced prior by clinical resource on 06/11/24 at 8:00 P.M. This training will be completed by 06/12/24. Any staff who are unable to complete this will be in-serviced prior to working their next shift. 6. An ad hoc meeting regarding items in the IJ template will be completed on 6/12/24. Attendees will include the Medical Director, Clinical Resource, [Director of Nursing] & Administrator and will include the plan of removal items and interventions. 7. The [MS] or designee will check call light system daily by manually testing bedside, toilet, and shower call light to ensure functioning properly until substantial compliance is met. 8. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. 9. Maintenance resource will train [MS] and/or designee on call light inspection and responsibilities. Designee will be trained on proper testing of call light system by 6/13/2024. [MS] will be in-serviced and trained upon hire on proper testing of call light inspection. Training time will be based upon previous experience and needs. 10. The ED/designee will ensure that the [MS] or designee is inspecting and maintaining the call light functionality. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Plan of Removal was monitored on 06/14/24 as followed: During an interview on 06/14/24 at 11:15 A.M, Administrator revealed the other three residents who were identified as having inoperable call lights did not have care plans revised because the residents opted to immediately move to a new room that had working call lights. Administrator stated Resident #48 and #34's care plans were initially revised to reflect preferences of staying in rooms with 1:1 monitoring until repairs were completed and deleted care plan interventions after call lights were repaired and in working condition. An observation of Life Safety Resource Manager on 06/14/24 from 11:19 A.M. through 11:35 A.M. revealed he tested all five identified residents' rooms, bathrooms, and shower call lights, which were all in working condition and turned on. During an interview on 06/14/24 at 11:35 A.M., Life Safety Resource Manager revealed he worked at the facility since 2018. Life Safety Resource Manager revealed the MS that was newly hired that had not started. Life Safety Resource Manager explained the former MS was terminated. Life Safety Resource Manager stated he trained four other maintenance workers on call light inspection and responsibilities on 06/13/24 and in-serviced on call light inspection, which was ongoing. Life Safety Resource Manager stated room assessments started on 06/16/24 and been ongoing. Life Safety Resource Manager no other residents were identified as having call lights not working. An observation of Resident #34's door on 06/14/24 at 11:50 A.M. revealed she had a posting indicating the empty bed in the room had a non-functioning call light. During an interview on 06/14/24 at 11:51 A.M., CMA S revealed she was in-serviced on call lights by the charge nurse. CMA S stated she learned the call light procedure, report to a nurse or the Administrator when call light does not work, if call light not working to also put in a work order, call light sign and bell usage, and identifying rooms with non-functioning call light systems. CMA S stated one male resident was moved to another room because his call light in his original room was not working and could not recall what day the move occurred. During an interview on 06/14/24 at 11:57 A.M., Resident #34 revealed she refused to move rooms despite her call light not functioning because she did not want all her equipment moved to another room. Resident #34 stated it was her preference not to move rooms. Resident #34 also stated staff provided her with a call bell and answered her call bell during the time her call light was repaired. During an interview on 06/14/24 at 12:01 P.M., CNA T revealed she was in-serviced on call lights, what to do when call lights go out, and same stuff been reviewed by the Administrator and Director of Nursing . CNA T stated she learned to check if the call lights worked by going into rooms, pressing call lights, and seeing if functioning, what to do when call lights did not work, and to be quick. CNA T also stated she was taught to notify a supervisor/charge nurse if call lights did not work. CNA T stated she was taught to ask residents if they want to move rooms, provide call bell, and make sure everything is in reach and checking on residents often (every 15min). An observation and interview of Resident #48 on 06/14/24 at 12:06 P.M. revealed she was sleeping in her wheelchair. Resident #48's family revealed staff did not offer Resident #48 with a new room, did not provide any way of being able to communicate to staff needs during time of call light not functioning, and call light been functioning good. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/14/24 at 12:24 P.M., CNA U revealed she was in-serviced on call light by the ADON or Director of Nurses and checked on residents often (every 30min) for those who had non-functioning call lights. CNA U stated she was taught to notify nurse when there was a non-functioning call light and putting in a work order, call bell usage, and identifying broken call lights through testing. During an interview on 06/14/24 at 12:28 P.M., LVN V revealed he was in-serviced on call lights online and by the Director of Nurses. LVN V stated he was taught how to report non-functioning call lights, call bell usage, and how to identify rooms with non-functioning call lights using signs and testing. During an interview on 06/14/24 12:30 P.M., CNA E revealed he was in-serviced on call lights by online. CNA E stated he was taught to report if seen non-functioning call lights, put in work order or report, post sign on door, and call bell usage. During an interview on 06/14/24 at 12:39 P.M, the Medical Director revealed he was notified of the IJ on 06/11/24 by the Director of Nurses and attended an Ad Hoc QAPI meeting on 06/12/24. During an interview on 06/14/24 at 12:43 P.M., DOR revealed she assisted in conducting room assessments for residents' call lights on 06/11/24. Attempted to contact the Assistant Business Office Manager on 06/14/24 at 12:44 P.M. Left a voicemail and call back number. The Assistant Business Office Manager did not return the call. During an interview on 06/14/24 at 12:47 P.M., the Call Light Company revealed they were called on 06/11/24 and addressed call lights at the facility on 06/12/24 and it was ongoing work. Attempted to contact Clinical Resource on 06/14/24 at 12:50 P.M. Left voicemail and call back number. The Clinical Resource did not return the call prior to exit. Attempted to contact ED on 06/14/24 at 12:51 P.M. Left voicemail and call back number. The ED did not return the call prior to exit. During an interview on 06/14/24 at 12:53 P.M., ADON revealed she assisted in conducting room assessments for residents' call lights on 06/11/24. During an interview on 06/14/24 12:57 P.M., Director of Nurses revealed she notified the MD of the IJ on 06/11/24. Director of Nurses stated she assigned staff to Resident #34 and #48 in shifts and documented on staff sign in sheet of those who provided 1:1 monitoring, and no issues reported. Director of Nurses also stated she attended Ad-Hoc QAPI meeting on 06/12/24. During an interview on 06/14/24 at 1:00 P.M., Administrator revealed there were two identified residents on 06/11/24 who immediately moved to another room following non-functional call light identification and no issues were reported since then. Administrator stated she was in-serviced by clinical resource on 06/11/24. Ad Hoc QAPI meeting was held on 06/12/24. No new identified residents with non-functioning call lights aside from the 2 residents identified . (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #48 and #34's initial care plan revisions revealed staff revised the care plans to reflect preferences during the time their call lights were not functioning. Record review of call light sign revealed staff used a sign indicating, Non-Functioning Call Light, to indicate a call light that was not functioning in a resident's room. Record review of staff daily assignment sheets on 06/11/24, 06/12/24, and 06/13/24. Resident #48 and #34's 1:1 monitoring assignment was listed too. Record review of the facility's resident call light system room assessment completed on 06/11/24 revealed one resident's bedroom call light was not working and two residents, Resident #48's and #34's bathroom and shower call lights were not working. Assessment completed on 06/12/24 revealed the same residents were identified. Assessment completed on 06/13/24 during the A.M. shift revealed the call light company was in the building working on call lights and no residents were identified as having call lights not working. Assessment completed on 06/13/24 during the P.M. shift revealed no residents were identified as having call lights not working. Record review of the facility's Call Light Assessment revealed staff identified four rooms that had defective call lights on 06/11/24. Two of the four rooms were Resident #48 and #34's bathrooms. The other two rooms were each located on the hallways Resident #48 and #34 resided on. Record review of the facility's call light staff instructions revealed staff were trained o n the following, If a call light was not working properly, staff should immediately notify their supervisor and put a work order in the work order system (Tels). Tels was the facility's system used to report any maintenance concerns. All staff members were responsible for residents' safety. If a call light was not working properly some of the interventions used are offering a different room or a bell/whistle. The way to identify a room with a non-working call light is a sign on the door with a bell and statement saying, Non-functioning call light. Record review of the in-services revealed the Administrator and Director of Nurses were in-serviced on 06/11/24 by two people on Call Lights. The facility's call light staff instructions were taught to the Administrator and Director of Nurses. The Administrator and Director of Nurses were also quizzed on what to do when a call light was not working properly, what system the facility used to report any maintenance concerns, who was responsible for resident safety, what were some of the implementations staff used when a call light was not working properly to ensure residents were safe and needs were being met, and how could staff identify rooms the call light system was not working. 33 staff members were also in-serviced and quizzed on the previously mentioned from 06/11/24 through 06/12/24. Record review of the staff in-services revealed staff were trained on Call Light Testing on 06/13/24. The following was covered, Testing of Call Light System; Bedside - Push button on Call Light Pendant; (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Toilet - Pull the Pull String next to toilet; Shower - Pull the Pull String in the Shower; The toilet and shower call light systems turned on a red light; Verify that it is notifying at the monitor at the nursing station; If not working properly or faulty notify Supervisor and put in work order (Tels). Record review of the Survey Remediation training revealed 2 staff completed the training on 06/12/24 and 1 staff on 06/13/24. Record review of the facility's undated Call Light policy and procedure revealed staff reviewed and revised policy to reflect if the call light/bell is defective, immediately report this information to the unit supervisor. Record review of the QAPI meeting on 06/12/24 revealed the Medical Director, Administrator, Director of Nurses, another Administrator, 3 RNs, and SW attended the meeting to discuss the facility's POR, in-servicing, and IJ. The Administrator and Director of Nursing were notified on 06/14/24 at 1:12 P.M. that the IJ was removed. The facility remained out of compliance at a scope of isolated and a severity level of actual harm that is not immediate jeopardy because of the facility need to evaluate the effectiveness of its corrective actions.