STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455278	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Healthcare and Rehab Center Inc	1208 N Llano Fredericksburg, TX 78624

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to electronically transmit encoded, accurate, and complete MDS data to the CMS System, within 14 days, upon a resident's transfer, reentry, discharge, and death, for 1 of 8 residents (Resident #25) reviewed for transmitted MDS data to the CMS System. The facility failed to transmit a discharge MDS assessment to the CMS system for Resident #25. This failure could place residents at risk for not having their assessments transmitted timely which could cause a delay in treatment. The findings included: A record review of Resident #25's admission record dated 10/03/2024, revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses which included heart disease and hypertension (high blood pressure). A record review of Resident #25's medical record revealed an admission MDS assessment dated [DATE] which revealed Resident #25 was a [AGE] year-old male admitted for care and assessed with a BIMS score of 15 which indicated no impairment to his cognition. Further review of Resident #25's medical record revealed no other MDS assessment and or transmittal to the CMS system. During an interview on 10/03/2024 at 06:44 PM, LVN C stated she was the MDS coordinator and began her position on 06/01/2024. LVN C stated Resident #25 had discharged to an assisted living facility on 06/18/2024 and she had not recognized the discharge and did not initiate an MDS discharge assessment to transmit to the CMS system. LVN C stated the electronic record system would prompt her to initiate discharge assessments for residents MDS transmittals to the CMS system for discharges within 14 days post discharge. LVN C stated she did not see Resident #25's discharge alert and did not produce the discharge assessment. LVN C stated the DON was her supervisor and was responsible for oversight of residents' discharges. (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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/04/2024 at 03:00 PM, the DON stated Resident #25 was discharged to an assisted living facility due to his improved health status and she had failed to have oversight to ensure Resident #25's MDS discharge assessment was captured and transmitted to the CMS system. The DON stated the failure to transmit accurate and timely MDS assessments could place residents at risk for harm by inaccurate records reported to the CMS system. A policy for MDS transmittals to the CMS system was requested on 10/4/2024 at 12:46 PM and the administrator stated the facility had no policy and followed and adhered to the HHSC guidelines at Resident assessments related to MDS assessments and reporting.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 of 3 the residents (Resident # 3) reviewed for oxygen in that: The Facility failed to ensure Residents #3's, nebulizer tubing was bagged. This deficient practice could place residents who received oxygen therapy at risk for an increase in respiratory complications. The findings were: Record review of Resident # 3's face sheet dated 10/1/24 revealed an 84-year female admitted to the facility on [DATE] with the diagnoses that included: Chronic Obstructive Pulmonary Disease [disease is characterized by breathlessness] ,Gastroesophageal reflux disease [condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach] and Major Depressive Disorder [mood disorder that causes a persistent feeling of sadness and loss of interest] . Record review of Resident # 3's Quarterly MDS dated [DATE] revealed a BIMS of 15, which indicated intact cognition. Record review of Resident #3's Physician monthly orders dated October 2024 revealed an order start date of 04/01/24: Albuterol Sulfate Inhalation Solution for nebulization 0.5 mg -3mg twice a day as needed for shortness of breath. Observation on 10/01/24 at 11:45 a.m. revealed that Resident # 3 's nebulizer tubing was unbagged on the bedside table. In an interview with Resident # 3 on 10/01/24, at 12:01 p.m., she stated they only bag the nebulizer tubing at this facility every once in a while, depending on the nurse. In an interview with RN A on 10/01/24, at 1:38 p.m., she stated she was the assigned RN to Resident # 3. It was revealed that it was every nurses responsibility to change nebulizer tubing weekly and bag them. However, she did not know why the nebulizer tubing was not being bagged. RN A stated that the Resident was at risk of possible respiratory infection due to the nebulizer tubing being undated and unbagged. During an interview with the (DON) on 10/01/24 at 3:55 p.m., it was revealed that Resident #3 should have had their nebulizer tubing changed and bagged by the night shift. The DON mentioned that she needed to determine why the nebulizer tubing was not bagged for Resident #3. She also stated that she oversaw this task and assured that she would monitor it for compliance. The DON stressed that Resident #3 was at risk of a possible respiratory infection due to the outdated and unbagged nebulizer tubing and unfortunately, she had no policy indicating that the nebulizer should be bagged.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on observation , interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record, and indicate the duration for the PRN order for 1 of 3 residents (Resident #150) reviewed for pharmacy services . The facility failed to ensure Resident # 150 had a stop date for PRN Lorazepam 0.5 mg (a medicine used to treat the symptoms of anxiety) This failure could affect residents who received antipsychotic/psychoactive medications and could place residents at risk of receiving unnecessary psychotropic medications. The findings included: Record review of Resident # 150's face sheet dated 10/02/24, reveled a 98- year old female admitted to the facility on [DATE] with diagnosis that included : [Anxiety] a feeling of fear, dread, and uneasiness , Type II Diabetes [condition that happens because of a problem in the way the body regulates and uses sugar as a fuel and Depression [a mood disorder that causes a persistent feeling of sadness and loss of interest. Record review of Resident #150 's most recent comprehensive MDS assessment, dated 9/19/2024 revealed the resident was moderately cognitively impaired for daily decision-making skills and was treated with anti-anxiety medications. Record review of Resident #150's comprehensive care plan dated 9/09/24 revealed the resident had a diagnosis of anxiety and used antianxiety medication as ordered by the physician with interventions monitor and document reactions to antianxiety medication such as confusion, and disorientation. Record review of Resident #150s Order Summary Report, dated 10/02/24 revealed the following: - Lorazepam Oral Tablet 0.50 MG, give 1 tablet by mouth every 4 hours as needed for anxiety disorder, with start date 9/20/24 and no stop date. Record review of Resident #150's Medication Administration Record for October 2024 revealed the following: - Lorazepam 0.50 mg was not administered PRN all month in September 2024. During an observation and interview on 10/02/24 at 1:30 p.m., Resident #150 was observed in wheelchair awake and alert. Resident # 150 stated she needed the anxiety medication at times but does not recall when she last had it . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/2024 at 1:25 p.m., during an interview, RN A disclosed that she had previously given lorazepam to Resident # 150 to help with anxiety. RN A explained that psychotropic medications like Lorazepam should be used for a limited time, not to exceed 14 days. After 14 days, the nurse is required to contact the physician to reassess the resident's need for the medication. RN A was unsure why the order for Lorazepam for Resident #150 was written for an indefinite period, and she expressed concern that the resident was at risk of confusion and disorientation by taking the medication for more than 14 days. During an interview and record review on 10/3/2024 at 2:30 p.m., the (DON) revealed that Resident #150 required the use of Lorazepam as recommended by the physician due to the resident's diagnosis. The DON stated that if the medication was taken all the time, it could result in Resident # 150 being overmedicated. After reviewing Resident # 150's order summary, the DON confirmed that there was no stop date on the order for prn Lorazepam. The DON revealed that the order for Lorazepam was possibly overlooked, The DON stated that she was currently responsible for overseeing that psychotropic drugs are limited to only 14 days, and she would start monitoring this monthly moving forward to prevent this from occurring again. Record review of the facility policy and procedure undated, Titled Medication Drug Review Regimen , revealed in part, When possible irregularities or unnecessary drugs are identified , the pharmacist shall prepare a drug irregularity report and submit the report to the DON .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, interview, and record review the facility failed to ensure its medication error rates were not 5% or greater. The facility had a medication error rate of 24%, based on 6 errors out of 25 opportunities which involved 1 of 3 residents (Resident #7) reviewed for medication administration and medication errors. 1. RN B crushed pills and capsules, 3 medications; bisacodyl 5mg delayed release, duloxetine 60mg delayed release, and divalproex 125mg delayed release, which should not be crushed per professional standards, and administered the crushed medications to Resident #7. 2. RN B administered acetaminophen 650mg, whole pill, to Resident #7 who was ordered by her physician to have crushed medications due to her swallowing difficulties. 3. RN B administered medication Carvedilol 6.25mg on 10/03/2024 at 10:01 AM, 1 hour late. 4. RN B administered medication acetaminophen 650mg on 10/03/2024 at 10:01 AM, 1 hour late. These failures could place residents at risk for not having the intended therapeutic benefit or an adverse reactions from the medication. The findings included: A record review of Resident # 7's admission record dated 10/03/2024 revealed an admitted [DATE] with diagnoses which included dysphasia pharyngoesophageal phase (a medical term for difficulty swallowing. Dysphagia can be a painful condition. In some cases, swallowing is impossible), heart failure, dementia (a group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives), and constipation. A record review of Resident #7's quarterly MDS assessment dated [DATE] revealed Resident #7 was an [AGE] year-old female Resident admitted for long term care and assessed with a BIMS score of 06 out of a possible 15 which indicated severe cognitive impairment. Resident #7 was assessed as having medical problems which included, a swallowing disorder, heart and respiratory debility, and a seizure disorder. A record review of Resident #7's care plan dated 10/03/2024 revealed, The resident has Congestive Heart Failure . Give cardiac medications as ordered . The resident has hypertension (HTN) r/t CHF. She is taking Coreg (carvedilol) two times daily . Give anti-hypertensive medications as ordered . has impaired cognitive function/dementia or impaired thought processes r/t Difficulty making decisions, Impaired decision-making, long-term memory loss, Short term memory loss . Administer medications as ordered uses antidepressant medication Cymbalta (duloxetine) r/t Depression . Administer antidepressant medications as ordered by physician (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #7's physicians orders, dated 10/04/2024, revealed on 06/14/2024, the physician ordered for Resident #7 to receive crushed medications. Further review revealed the physician ordered on 12/01/2021 for Resident to have medications, may alter medication by crushing, opening caps, or administering in foods or fluids. (Only open or crush if manufacture allows) A record review of Resident #7's physicians orders dated 10/04/2024 revealed Resident #7 was ordered to receive, bisacodyl 5mg delayed release (a stool softener), duloxetine 60mg delayed release (an anti-depressant), divalproex 125mg delayed release (anti-seizure medication) twice a day at 09:00 and at 06:00 PM, acetaminophen 650mg (a non-steroidal pain relief medication) three times a day at 08:00 AM, 01:00 PM, and at 08:00 PM, and carvedilol 6.25mg (a medication to treat high blood pressure) at 08:00 AM and at 05:00 PM. During an observation on 10/03/2024 at 10:01 AM, RN B prepared and administered bisacodyl 5mg delayed release pill, duloxetine 60mg delayed release pill, and divalproex 125mg delayed release pill by crushing the medications. Further observation revealed RN B administered acetaminophen 650mg enteric coated delayed release pills whole without crushing and 1 hour late. Further observation revealed RN B administered carvedilol 6.25mg 1 hour late. During an interview on 10/03/2024 at 10:10 AM, RN B stated she had administered the bisacodyl, duloxetine, and the divalproex by crushing the medications because she believed she could crush those medications and administered the acetaminophen whole because Resident # 7 could tolerate some pills whole. RN B stated she did administer the carvedilol and the acetaminophen 1 hour late, RN B stated she had not reported to her supervisor, the DON, any potential late medication administrations . During an interview on 10/03/2024 at 01:00 PM, the DON stated RN B had not reported any potential late medication administrations. The DON stated Resident #7's bisacodyl, duloxetine and divalproex medications were delayed release formulations and should not be crushed and were inappropriate formulations for Resident #7. The DON stated Resident #7 was prescribed crushed medications due to Resident #7's swallowing difficulties and should not be administered whole pills. The DON stated her expectations and facility policy was for residents to receive their medications as ordered and within 1 hour of their scheduled administration. The DON stated the nurse was counseled and received re-enforced training on safe medication administration, Resident #7 was assessed without injury, and the physician received a report of the medication errors and Resident #7 did not receive any new orders. The DON stated medication error could place residents a risk form harm by adverse effects of the medication administration errors. A record review of the Institute for Safe Medication Practices website; https://www.ismp.org/sites/default/files/attachments/2018-02/tasm.pdf Accessed 10/04/2024, titled ISMP Acute Care Guidelines for Timely Administration of Scheduled Medications revealed, Medications administered more frequently than daily but not more frequently than every 4 hours (e.g., BID, TID, q4h, q6h) Administer these medications within 1 hour before or after the scheduled time. A record review of the facility's undated Medication Error policy revealed, It is the policy of (facility), Inc. to be free of significant medication errors and error rates. A medication error report (see next page for example) will be filled out for each medication or treatment error. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PURPOSE: To define error, investigate error, determine reason for error and consider preventative measures. MEDICATION ERROR: Federal regulations state a medication error is a discrepancy between what the physician ordered and what is actually administered. Significant medication error causes the resident discomfort or jeopardizes his or health and sample. Example are listed below: o Omissions o Unauthorized drugs (drugs administered without a doctors order) o Wrong Dose o Wrong route of administration o Wrong dosage form o Wrong time including AC's give PC or vice versa or drug administered 60 minutes earlier or later than scheduled time. Any medication error must immediately be reported to the resident's attending physician, a medication error form completed, and the immediate supervisor notified. A record review of the bisacodyl manufactures website; https://healthy.kaiserpermanente.org/health-wellness/drug-encyclopedia/drug.dulcolax-bisacodyl-5-mg-tablet-delayed-release.297753 Accessed 10/04/2024, titled Drug Encyclopedia Ducolax (bisacodyl) 5mg tablet, delayed release revealed, How to use: Take this medication by mouth as directed by your doctor. If you are self-treating, follow all directions on the product package. If you have any questions, ask your doctor or pharmacist. Swallow this medication whole. Do not crush, chew, or break the tablet or take it within 1 hour of antacids, milk, or milk products. Doing so can destroy the coating on the tablet and may increase the risk of stomach upset and nausea. A record review of the United States of America's Food and Drug Administrations website; https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022516lbl.pdf accessed 10/04/2024, titled Cymbalta (duloxetine hydrochloride) Delayed-Release Capsules for Oral revealed, DOSAGE AND ADMINISTRATION Cymbalta should be swallowed whole and should not be chewed or crushed, nor should the capsule be opened and its contents sprinkled on food or mixed with liquids. All of these might affect the enteric coating. A record review of the United States of America's Food and Drug Administrations website; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/018723s037lbl.pdf , accessed 10/04/2024 titled Depakote (divalproex sodium) Tablets for Oral use revealed, Swallow Depakote ER tablets or DEPAKOTE delayed-release tablets whole. Do not crush or chew them. Tell your healthcare provider if you cannot swallow Depakote ER tablets or DEPAKOTE delayed release tablets whole. You may need a different medicine. A record review of the acetaminophen manufactures website; https://healthy.kaiserpermanente.org/health-wellness/drug-encyclopedia/drug.tylenol-8-hour-650-mg-tablet-extended-release.450881 , accessed 10/04/2024, titled Tylenol (acetaminophen) 8 Hour 650 mg tablet, extended release revealed, How to use . Do not crush or chew extended-release tablets. Doing so can release all of the drug at once, increasing the risk of side effects. Swallow the tablets whole.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 41937 Based on observations, interviews, and record reviews the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 of the facility's laundry department reviewed for patient care equipment in safe operating condition. The facility presented 4 installed dryers of which 2 were inoperable and the facility presented with 3 washers of which 2 were inoperable. These failures could place residents at risk for harm by the facility's inability to provide clean sanitary linens. The findings included: A record review of the facility's census Resident List Report dated 10/01/2024 revealed a census of 50 residents. During an observation on 10/01/24 at 09:59 AM, the facility's laundry department revealed 3 commercial washers of which 1 of the 3 was operational. Further review revealed 4 commercial dryers of which 2 were operational. During an interview on 10/03/2024 at 10:10 AM, laundry Aide D stated she had been the laundry attendant for the past year and of the 3 washers only 1 worked and of the 4 dryers only 2 worked. Laundry Aide D stated the dryers and washers had been inoperable for months. Laundry Aide D stated she was able to provide clean linens for the facility's residents with the current operational equipment but could be challenged to provide clean laundry if the demand increased with an increased census . During an interview on 10/04/2024 at 01:30 pm, the Administrator stated she had been attempting to secure BIDS and funding for the repair and or replacement of the dryers and washers and had not yet secured the equipment repairs or replacement. The administrator stated the facility had just bought the 1 operational commercial washer . A policy for maintaining essential equipment for resident care was requested on 10/4/2024 at 12:46 PM and the administrator stated the facility had no policy and followed and adhered to the HHSC guidelines at maintaining essential equipment.

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F 0919 Level of Harm - Minimal harm or potential for actual harm 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** 41937 Based on observations, interviews, and record reviews the facility failed to ensure residents could 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 each resident's bedside for 1 of 8 residents (Resident #16) reviewed for the ability to call for staff assistance. The facility failed to ensure Resident #16's call light was within reach while she was positioned in her wheelchair. This failure could place residents at risk for delay in care and services, and increased risk of falls and injuries. The findings included: A record review of Resident #16's admission record dated 10/03/2024 revealed an admitted [DATE] with diagnoses which included Parkinson's disease (a movement disorder of the nervous system that worsens over time. Parkinson's symptoms may include tremors, slowed movement, rigid muscles, and poor balance), spinal stenosis (a condition that narrows the spaces in your spine, squeezing your spinal cord and nerves.), and incontinence without sensory awareness. A record review of Resident #16's quarterly MDS assessment dated [DATE] revealed Resident #16 was an [AGE] year-old female admitted for long term care and assessed as medically complex with a BIMS score of 09 out of a possible 15 which indicated a mild cognitive impairment. Resident #16 was assessed as totally dependent on staff for activities of daily life (toileting, positioning, and hygiene) and required a wheelchair. A record review of Resident #16's care plan dated 10/03/2024 revealed, (Resident #16) is High risk for falls r/t Gait/balance problems, Hypotension r/t Parkinson's Disease. She had a fall 5/1/24 . Anticipate and meet The resident's needs . Be sure The resident's call light is within reach and encourage the resident to use it CNA for assistance as needed. The resident needs prompt response to all requests for LPN assistance. During an observation and interview on 10/03/2024 at 09:17 AM, revealed Resident #16 was seated in her wheelchair in her room, alone without staff, approximately 4- 6 feet away from her call light. The call light was dangled off of the bed, above the floor. Resident #16 requested help from the surveyor and stated she was uncomfortable due to her position in the wheelchair. Resident #16 stated her lower back was in pain with some clothing and or adult brief binding her. Resident #16 stated if she attempted to stand she would fall. The surveyor alerted staff and CNA E stated Resident #16's call light was out of Resident #16 reach. CNA E repositioned Resident #16 and repositioned her call light to be at Resident #16's side. During an interview on 10/04 2024 at 03:45 PM the DON stated her expectation, and the facility policy was for residents to have their call lights within their reach when in their rooms. The DON stated the inability for residents to call staff for assistance could lead to falls. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Healthcare and Rehab Center Inc	1208 N Llano Fredericksburg, TX 78624

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's Call Light use of policy dated 2005, revealed, BASIC RESPONSIBILITY; Licensed Nurse and Nursing Assistant, all Facility Staff. PURPOSE; To respond promptly to resident's call for assistance. To assure call system is in proper working order. EQUIPMENT; Bedside call light in functioning order . When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light