STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455662	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of McAll	900 S 12th St McAllen, TX 78501

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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 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** 50532 Based on interview and record review the facility failed to ensure the resident's right to formulate advance directives for 1 (Resident #72) of 8 residents reviewed for advance directives. The facility failed to ensure that Resident #72's Advance Directive was signed by the family representative and code status was entered as DNR in the records at the facility. This failure could place the residents at risk of not having their end of life wishes honored, such as receiving unwanted resuscitative measures. Findings included: Record review of Resident #72's face sheet dated 09/12/24 reflected she was a [AGE] year-old female that was admitted to the facility on [DATE]. Her diagnoses included Metabolic encephalopathy (a brain dysfunction caused by an underlying condition), repeated falls, Alzheimer's Disease (a gradual decline in memory, thinking, behavior and social skills), unspecified, Hyperlipidemia (high cholesterol and triglycerides), unspecified, Age-related physical debility, Depression, Essential Hypertension (high blood pressure). Record review of MDS dated [DATE] Resident #72's a BIMS score of 1, indicating Resident #72 cognition was severely impaired. Record review of Resident #72's physician order summary report, dated 09/12/24, had an active physician's order for code status: DNR (Do Not Resuscitate) dated 03/04/2024. Record review on 09/10/24 at 01:43 PM revealed OOHDNR not signed in PCC only statement verbal consent given by FM for DNR but resident profile on PCC states DNR. Record Review of Resident #72's Care Plan identifies Resident 72 as a DNR initiated 06/13/2024 and revision on 06/13/2024. Interventions listed to ensure signed DNR is in medical record, with date initiated 06/13/2024. (continued on next page)

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	Interview with the SW on 09/11/24 on 04:36 PM, she stated that upon admission and care planning meetings code status was discussed whether full code and if there was a decline then different options were discussed with the resident and family. She stated she had DNR forms and will assist the family with DNR form completion. The family signs with a witness. The SW recalled Resident 72's DNR and stated, yes on Resident 72's, Daughter 1 stated that Daughter 2 would come and sign the DNR and SW wrote verbal signature on DNR form. The SW stated she talked to Daughter 1 on Friday 09/06/24 and she stated again that Daughter 2 was supposed to come sign during the weekend. Resident 72's Daughter 2 did not come and sign DNR. The SW stated that she would usually follow up within a week of verbal consent. The SW stated sometimes family works during the week and cannot come in and it was easier on the weekend to get the family to come in and sign documents. The SW stated she would call Resident 72's and follow up again today. Record Review of Resident #72's progress notes had late entry on 9/11/24 7:03pm by Social Worker effective 09/06/24 6:14 PM stated Resident #72 has Advanced Directives in place, resident/family want no life sustaining treatment; copy of Advanced Directives is on file. Resident #72's Daughter 1 and Daughter 2, h ave Medical POA, copy is on file. As per family/ advanced directives, Resident #72 is DNR. Called both Daughter 1 and Daughter 2 on Friday 9/6/24 to remind them to come by and sign a revised OOH DNR Form with their signature. Record Review on 09/12/24 at 11:44 AM revealed signed DNR noted in PCC with signature of Daughter 2 , above statement that read verbal consent, but no current date was noted. Interview with the Medical Records Nurse on 09/12/24 at 1:47 PM, she stated that once DNRs were signed she would upload them, but the social worker now usually uploaded and also gets the MD signatures on the DNRs herself. She stated that SW or herself would audit randomly to ensure DNRs were filled out and signed but Medical Records Nurse could not provide how often her and SW audit, stated just random. Interview with the DON on 09/12/24 at 01:52 PM she stated that Social Worker was responsible for DNRs. The team that consists of the MDS nurse, ADON, DON, and SW, review orders in morning meeting and make sure if DNR the form was in place to determine code status. The DON stated that to her knowledge a DNR needed to be signed by family and physician. The DON stated no negative effects for Resident #72, because if DNR was the family's wishes, the facility usually contacted the family on the phone and a signature might not be there, but the facility can verbally get consent and be aware of the family request and aware of the resident's code status. Record review of the facility's policy subject titled, Residents Rights Regarding Treatment and Advance Directives, Implemented October 24, 2022, revealed Policy Statement It is the policy of this facility to support and facilitate a resident right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Policy Explanation and Compliance Guidelines 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive.

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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** 50532 Based on interview and record review, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Evaluation assessment for 1 of 3 residents (Resident #28) reviewed for preadmission screenings. The facility failed to refer Resident #28 for PASRR Evaluation after a positive PASRR 1 screening. This failure could place residents at risk of receiving inadequate care. Findings included: Record review of Resident #28's admission record dated 09/12/24 revealed a [AGE] year-old male with an original admitted on 09/10/2020 and a readmission on 10/07/2023. Diagnoses included Major Depressive Disorder, Bipolar Disorder, Other specified anxiety disorders, and Delusional Disorders. Record review of Resident #28's care plan identified on pg. 12 a problem dated 02/12/2024 of behavior problem related to Mood Disorder, Delusional Disorder, Bipolar Disorder. Resident will at times asks repetitively for assistance when needs have been met and is forgetful, attention seeking. Revised: 08/13/2024. In an interview with the RN MDS on 09/11/24 at 11:49 AM stated he was responsible for uploading [NAME] screenings to the portal for LIDDA. RN MDS also stated that he would look for PASRR for Resident #28 and 2 other PASRR for residents that were not uploaded to PCC. On 09/12/24 at 09:10 AM RN MDS provided PASRR for Resident #28 and other residents. Record review of Resident #28's PASRR Level 1 Screening dated 09/20/20 Section C. was positive for Mental Illness In an interview with the RN MDS on 09/12/24 09:30 AM, he stated that he was still looking for PASRR 2 Evaluation for Resident #28 because he could not find it and if not found he would call the LIDDA to reassess. In an interview with the RN MDS on 09/12/24 at 1:44 PM, he stated that PASRR 2 was not found but LIDDA would be there today to re-evaluate the resident. He stated that PASRR 1 screening was just uploaded and then the LIDDA would come and do the PASRR 2. He stated that should the resident need specialized services and he then deferred to regional MDS nurse. In an interview with the Regional RN MDS on 09/12/24 at 1:45 PM, he to question of what could be a negative outcome for the resident for not having PASRR 2 with if he needed skilled therapy, then it would ensure he got the therapy. In an interview with the RN MDS on 09/12/24 at 1:46 PM, he then stated the negative outcome would be that the resident would not receive services if need be that he needs. He reiterated that assessment would be completed today as per LIDDA. LIDDA was coming today. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 09/12/24 at 1:55 PM, she stated that MDS Nurse was responsible for PASRRs. PASRR 1 Screening was only done by the facility for admissions from home, but usually admissions from hospital or other facility they have PASRR 1 screening prior to admission. She stated there was a thread email with administration department that includeds DON and MDS to make sure PASRR were in place before a resident wasis admitted into facility and if positive MDS ensures PASRR 2 gets done. She stated a negative outcome would be that when followed by LIDDA that the entity is not aware that the resident is in-house. Record Review of Detailed Item-by-Item Guide for Completing the authorization Request for PASRR Nursing Facility Specialized Services Form dated September 2023 by Texas Health and Human Services Reference Services, provided by the facility when asked for policy for PASRR, stated on page 5 under heading PL1 Screening Form If documentation entered on the PL1 Screening Form indicates a suspicion of MI/ID/DD, a PASRR Evaluation (PE) must be completed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on record review and interview the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for one (Resident #53) of five residents whose medications were reviewed. The facility's Pharmacy Consultant recommended the physician consider a GDR for the Keppra and the Trazodone on 05/30/24. The facility failed to ensure the physician documented his rationale for not making any changes to Resident #53's medication therapy. This failure could place residents receiving psychotropic medications at risk for adverse consequences and could cause a decline in their physical, mental, and psychosocial condition. The findings were: Record review of Resident #53's Face Sheet dated 09/12/24 revealed Resident #53 was admitted to facility on 11/28/23. Resident #53 was a [AGE] year-old female with diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of cognitive functioning), major depression disorder, recurrent, severe without psychotic features (mental health disorder characterized by persistently depressed mood), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder). Record review of Resident #53's e-MAR for September 2024 revealed orders: -trazodone HCl, oral tablet 50mg, give one tablet by mouth at bedtime for insomnia -Keppra Solution, 100 mg/ml (Levetiracetam), give 5 ml by mouth two times a day for labile moods, give 5ml to equal 500mg, start date of 2/13/24. Record review of Resident #53's e-MAR for September 2024 revealed: -trazodone was administered daily at bedtime from 09/01/24 through 09/11/24. -Keppra Solution was administered twice a day from 09/01/24 through 09/12/24. Record review of Resident #53's quarterly MDS assessment dated [DATE] revealed Resident #53 was sometimes understood by others and would sometimes understand others, was unable to complete a Brief Interview for Mental Status, had long term and short-term memory problems. Resident #53 had received antidepressant medications in the last 7 days. Record review of Resident #53's care plan dated 06/05/24 revealed Resident #53 used antidepressant medication r/t depression, insomnia. The intervention included: -administer antidepressant medications as ordered by physician (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-monitor/document/report PRN adverse reactions to antidepressant therapy; change in behavior/mood/cognition; hallucinations/delusions; social isolation; suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, fall; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting, dry mouth, dry eyes. Record review of Resident #53's care plan dated 06/05/24 revealed Resident #53 used antidepressant medication r/t depression, insomnia. The intervention included: -administer antidepressant medications as ordered by physician -monitor/document/report PRN adverse reactions to antidepressant therapy; change in behavior/mood/cognition; hallucinations/delusions; social isolation; suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, fall; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting, dry mouth, dry eyes. Record review of the Pharmacy Consultant letter titled Consultant Pharmacist/Physician Communication dated 05/30/24 revealed: The resident has orders for Keppra 500 mg BID since 02/13/24 for labile moods and Trazodone 50 mg QHS for insomnia since 02/01/24. An attempt for gradual dose reduction of Keppra and Trazodone should be attempted. If appropriate, please consider a GDR of Keppra and Trazodone. If not appropriate, please document rationale for contraindication. Thank you for your consideration. Reduce Keppra to 250 mg QD and 500 mg QHS. Reduce Trazodone to 25 mg QHS. Keep both medications as is, due to ____ Physician/Prescriber Response Agree __ Disagree __ Other __ The physician checked disagree and signed the form on 06/10/24 but did not provide a rationale. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/12/24 at 12:33 p.m., the ADON said when the pharmacy consultant made a recommendation the form was sent to the doctor. The doctor would either agree with the recommendation or disagree, but the doctor had to document a reason he was disagreeing with the recommendation. The ADON said the DON was responsible for reviewing the recommendation and calling the doctor to clarify if it was not clear or was missing the rationale. The ADON said the negative outcome would be that the resident might be overmedicated. In an interview and record review on 09/12/24 at 12:38 p.m., the DON said she or the ADON were responsible for reviewing the Pharmacy Consultant recommendations. The DON said she rounded with the Psychiatric NP so that they can go over the recommendations. The DON said if the NP did not write a rationale, she would ask her to write a rationale. The DON said usually the NP would only write Stable. The DON said many of the doctors would only check or disagree and it was sometimes difficult to get them to write a rationale. The DON said sometimes the NP would write the rationale on the progress note. The DON and surveyor reviewed Resident #53's Progress Notes in PCC and did not find any Progress Notes for the Pharmacy recommendation dated 05/30/24. The DON said she would check other Progress Notes. The DON said they do audit the progress notes and the orders for psychotropic medications. In an interview on 09/12/24 at 12:59 p.m., the DON said she had reviewed Resident #53's progress notes and was not able to find a progress note with a rationale for refusing the GDR for the Keppra and the Trazodone. In an interview on 09/12/24 at 6:45 PM, the Pharmacy Consultant said if a physician refused the recommendation for a GDR, they needed to provide a rationale to comply with regulations. Record review of the facility's policy for Medication Regimen Review dated 11/28/22 revealed The Medication Regimen Review (MRR), or Drug Regimen Review, is thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. Record review of the facility's policy for General Policy & Procedures, Subsection: Consultant Pharmacist Services and Reports dated 10/01/19 revealed: Subject: Medication Management In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. When selecting medication and non-pharmacological interventions, members of the interdisciplinary team participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48278 Based on interview and record review, the facility failed to ensure the resident was not given a psychotropic drug unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 3 (Resident #34, Resident# 59, and Resident #25) of 4 residents reviewed for unnecessary medications, in that: 1.Resident #34 was receiving Prozac (an antidepressant) without adequate indication for its use or an appropriate diagnosis. 2. The facility failed to have an adequate diagnosis or indication for the use of the medication Gabapentin (anti-epileptic drug, used for seizures and some types of pain, with off-label use of anxiety, insomnia, and bipolar disorder) for Resident #59. 3. Resident #25 was prescribed a psychotropic drug for anxiety without a documented diagnosis of anxiety in the clinical record. This failure could place residents at risk of receiving unnecessary psychotropic medications. Findings included: 1. Record review of Resident #34's Face Sheet dated 09/12/24 revealed Resident #34 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (degenerative brain disorder), vascular dementia of unspecified severity (condition caused by the lack of blood that carries oxygen and nutrients to the brain), with other behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition (trouble tell what's real and what's not), and major depressive disorder, single episode (mental health disorder characterized by persistently depressed mood). Record review of Resident #34's Physician's Orders for September 2024 revealed an order for Prozac oral capsule 40 mg (Fluoxetine HCL), give 1 capsule by mouth one time a day for dementia with a start date of 01/28/23. Record review of Resident #34's e-MAR for September 2024 revealed Resident #34 was administered Prozac oral capsule 40 mg 09/01/24 through 09/12/24. Record review of Resident #34's quarterly MDS assessment dated [DATE] revealed Resident #34 was usually understood by others, would usually understand others, and had severe cognitive impairment and was receiving antipsychotic and antidepressant medications on a routine basis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #34's revised care plan dated 06/01/24 revealed Resident #34 used antidepressant medication (Prozac, trazodone) r/t depression, insomnia. The interventions were to administer the antidepressant medications as ordered by physician, monitor/record occurrence of target behavior symptoms and document in progress notes. Monitor/document/report PRN adverse reactions to antidepressant therapy. Prozac had a black box warning: Suicidality and antidepressant drugs Antidepressants increased the risk compared with placebo of suicidal thinking and behavior (suicidality) in short-term studies in children, adolescents, and young adults with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of fluoxetine or any other antidepressant in a child, adolescent or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared with placebo in adults older than [AGE] years; there was a reduction in the risk with antidepressants compared with placebo in adults [AGE] years and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Appropriately monitor and closely observe patients of all ages who are started on antidepressant therapy for clinical worsening, suicidality, or unusual changes in behavior. Advise families and caregivers of the need for close observation and communication with prescribing health care provider. In an interview on 09/12/24 at 12:05 p.m., the ADON stated MDS staff puts in the diagnosis in PCC. The ADON stated the negative outcome of not having a diagnosis in the resident's chart was that she would not have a bad reaction but if it was a different patient with no diagnosis, they would be overmedicating them. In an interview on 09/12/2024 at 12:37 p.m., the DON stated the nurses were responsible to enter new orders from doctors into the chart. The DON stated the RN MDS nurse does that update on the MDS for the diagnosis. The DON stated that in the mornings they go over any new orders, the MDS RN attends these. The DON said they do audit the progress notes and the orders for psychotropic medications. The DON said she would check other Progress Notes. In an interview on 09/12/24 at 12:59 p.m., the DON said she had reviewed Resident #34's progress notes and was not able to find a progress note from the physician documenting the reason why he put dementia as the indication for the Prozac. In an interview on 09/12/24 at 4:00 p.m., LVN C said she did provide care to Resident #34 and was familiar with Resident #34. LVN C said she was not familiar with the medication Prozac. LVN C said since she did not know what the medication was used for, she could not say if the diagnosis of dementia was correct or not and did not know if what the negative outcome would be. LVN C said the Med Aides were usually the ones to give those medications. 2. Observation of medication pass on 09/11/24 08:09 AM included Resident #59, the resident received Gabapentin 300mg 1 capsule by mouth two times a day for anxiety as per instructions on blister pack. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #59's face sheet dated 09/12/24 indicated Resident #59 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of Need for Assistance with personal care, cognitive communication deficit, mood disorder due to known physiological condition, unspecified, restlessness and agitation, unspecified symptoms and signs involving cognitive functions and awareness, major depressive disorder, recurrent severe without psychotic features, insomnia, unspecified, Gastro-esophageal reflux disease without esophagitis, dentofacial functional abnormalities, unspecified. Unspecified protein-calorie malnutrition encephalitis and encephalomyelitis, unspecified, other amnesia, Depression, unspecified. The Admission Record did not include a diagnosis of Anxiety. Record review of Resident #59's Quarterly MDS dated Section I Active Diagnosis with Psychiatric/Mood Disorder identifies I5800 Depression only. Section N Medications N0415 High Risk Drug Classes: Use and Indication identifies antidepressant, antibiotic and hypoglycemic as was taking and indication noted. Record review of Resident #59's Physician's Orders for September of 2024 revealed an order dated 04/01/2024 for Gabapentin Oral Capsule 300mg (Gabapentin), give one capsule by mouth two times a day for Anxiety with start date of 04/01/2024 and no end date, side effect monitoring for anti-convulsant Q Shift with start date of 03/29/2023. Record review of Resident #59's e-MAR dated September of 2024 revealed the medication Gabapentin oral capsule 300mg was administered to Resident #59 on 09/01/24 through 09/12/24. Record review of Resident #59's consents had a consent for Gabapentin for Anxiety signed by guardian on 03/17/23. Record review of the Pharmacy Recommendations for Resident #59 had a GDR recommended by pharmacist for Trazadone and Gabapentin on 7/30/24 but healthcare provider disagreed and documented needs to sleep signed and dated 8/8/24. Record review of Resident #59's care plan revealed that Resident #59 was physically aggressive at times towards staff and other residents' r/t Dementia. Date Initiated: 09/01/2023 Revision on: 05/29/2024 and only mention of anxiety in care plan was in recommendation COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Date Initiated: 09/01/2023. During Interview with LVN E on 09/12/24 at 12:16 PM, she stated she worked at facility since 07/08/24, and was reviewing Resident #59's orders on the MAR. She stated Resident has had Gabapentin since April but she has not seen it prescribed for anxiety, mostly for pain. She was reviewing to see if diagnosis for anxiety was in the chart. I don't see that condition on diagnosis. She stated that she knew that Resident #59 could be a little nervous, but usually happy and good patient. During an interview with the DON on 09/12/24 at 05:49 PM she provided diagnosis of anxiety on [name of health system] 03/21/21 prior to admission, and she provided article of case study of a patient treatment of generalized anxiety disorder with Gabapentin. (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Pharmacy Consultant on 09/12/24 at 06:04 PM, she stated there's a lot of uses for gabapentin neuropathy, and behaviors, a variety of different behaviors, let me think, mood disorder, whenever they are having mood, change in moods, mixed mood disorder, any particular diagnosis, mood disorder psychiatrist but sometimes anxiety but in general mood disorders for behaviors. She stated that usually for Gradual Dose Reduction recommendations the physician does put a reason or rationale when in disagreement with recommendations . 3. Record review of Resident #25's face sheet dated, 09/06/2024, revealed a [AGE] year-old resident initially admitted on [DATE] with diagnosis including Alzheimer's Disease, Depressive Disorder, Essential Hypertension (high blood pressure), Chronic Obstructive Pulmonary Disease (lung disease causing restricted airflow and breathing problems.), Dysphagia (swallowing difficulties), Type 2 diabetes mellitus (long-term condition in which body had trouble controlling blood sugar). Record review of Resident #25's Comprehensive MDS Assessment , dated 07/16/2024, revealed Resident #25 had a BIMS score of 05 which indicated her cognition was severely impaired. Record review of Resident #25's Care Plan, dated 08/06/2024, revealed that Resident #25 used anti-anxiety medications (Buspirone) r/t anxiety disorder. Interventions: Administer Anti-Anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. Record review of Resident #25's Physician Orders dated 09/11/2024 showeds Resident #25 was still prescribed Buspirone 5mg 1 tablet once a day (start date was 09/12/2024), and the diagnosis listed for Buspirone was Anxiety. During an interview on 09/12/2024 at 11:55 a.m. with LVN B, stated she was Resident #25's nurse and was familiar with her care. She stated she was giving Buspirone medication to Resident #25 for anxiety. She stated she was responsible for entering the medication orders. LVN B stated the orders reflect in the e-MAR and that was what she follows. She stated when entering these orders, it would ask what diagnosis the medication was used for. She stated she updated Residents #25 Buspirone yesterday, dosage was decreased. LVN B checked in the facility's electronic health records under the medication diagnosis tab and confirmed that there was no Anxiety diagnosis for Resident #25. She stated she was not sure who entered that information in the chart. During an interview on 09/12/2024 at 12:05 p.m. with the ADON, stated Resident #25 was taking Buspirone from the hospital and medications get verified with the doctor. She doesn't know why they overlooked putting the diagnosis in the chart. She stated MDS staff put in the diagnosis on PCC. The ADON stated the negative outcome of not having a diagnosis in Resident #25's chart was that she will not have a bad reaction but if it was a different patient with no diagnosis, they would be overmedicating them. (continued on next page)

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	455662	A. Building B. Wing	09/12/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/12/2024 at 12:23 p.m. the RN MDS, stated that the nurses could enter the diagnosis in the chart and that he could also enter the diagnosis as well. The RN MDS reviewed the facility's electronic health records chart, he stated he hadn't reviewed Resident #25's chart since the last MDS which was done on 07/16/2024. He stated he reviewed them quarterly. The RN MDS stated that the charge nurse, ADON, or DON were supposed to let him know of any new orders so that if they don't put it in then he could put it in the resident's chart. He stated the negative outcome would be that perhaps other physicians might not see the diagnosis and might not see that she has those conditions. Therefore, they might not know what she was on and might prescribe something else. The RN MDS stated that this one got overlooked, nobody caught it. During an interview on 09/12/2024 at 12:37 p.m. with the DON, stated Buspirone was an antianxiety medication. She stated the nurses were responsible when they get new orders from the doctors to enter it in the chart. She stated the RN MDS nurse did not do that update on MDS for the diagnosis. The DON stated that in the mornings they reviewed any new orders, the MDS RN attended those. She stated they reviewed every week the antipsychotics, but they unfortunately missed this one. During an interview via phone on 09/12/2024 at 6:45p.m. with the pharmacy consultant, stated that Buspirone medication was used for the diagnosis of Anxiety. Record review of facility's Psychotropic Medication Policy, date implemented 08/15/22, revealed: Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Policy Explanation and Compliance Guidelines: 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, Anti-anxiety, and hypnotics. 4. The indications for use of any psychotropic drug will be documented in the medical record. b. For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable disease and infection for 2 (Resident #16 and Resident #45) of 16 residents reviewed for infection control, in that: 1. The facility failed to ensure LVN A changed his gloves when moving from a dirty to clean task during wound care on Resident #16. 2. The facility failed to ensure LVN D cleaned the stethoscope prior to checking placement of peg tube during the task of medication administration on Resident #45. These failures could place resident at risk for infection due to improper care practices. Findings included: 1.Review of Resident #16's Face Sheet, dated 09/12/2024, reflected resident was an [AGE] year-old female admitted on [DATE], with an initial admitted date of 05/07/2021. Relevant diagnoses included Pressure Ulcer of Sacral Region, Stage 4, unspecified Dementia, Chronic Pulmonary Edema (a condition in which fluid builds up in the lungs, making it difficult to breathe), Type 2 Diabetes Mellitus (long-term condition in which body has trouble controlling blood sugar), Hypertensive Heart Disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure), Depressive Disorder, Gastrostomy Status (a tube inserted through the abdomen and into the stomach used for feeding). Review of Resident #16's Quarterly MDS Assessment, dated 06/09/2024, reflected Resident #16 was not able to conduct the BIMS due to Resident #16 was severely impaired. Resident #16 had a pressure ulcer over bony prominence. Review of Resident #16's Comprehensive Care Plan, dated 06/14/2024, reflected Resident #16 currently had a stage 4 pressure ulcer to her sacrum. Interventions: Apply treatment per Medical Practitioner's Order. Assess and document on status of pressure ulcer as needed. Treat pain as per orders prior to treatment to ensure the resident's comfort. Inform the resident/family/caregivers of any new area of skin breakdown. During an observation and interview of wound care to Resident #16 on 09/11/2024 at 10:45 a.m. revealed LVN A removed the old soiled dirty dressing from Resident #16's sacral pressure wound then without changing his gloves continued to cleansed area and continued to pat dry. He stated he forgot to change them out and do hand hygiene in between glove changes. He stated that he knew that he was supposed to change gloves and do hand hygiene after removing the dirty soiled dressing. He stated changing gloves was good infection control practice to eliminate cross contamination. During an interview on 09/11/24 at 11:30 a.m. with the ADON, stated LVN A had training on wound care. She stated she did the training on wound care upon hire and annual check offs. She stated in-service for infection control was done this week on PPE, handwashing, and EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/11/24 at 11:55 a.m. with the DON, stated the facility does wound care training annually and every six months if needed. She stated that the staff should remove gloves, wash their hands, and put on new gloves after removing the soiled dressing. The DON stated it was important to change gloves and conduct hand hygiene to prevent cross contamination. Record Review of LVN A, Wound Treatment Competency Assessment was completed on 08/24/24, revealed he passed with the facility's standard of practice. Record Review of the facility's Wound Treatment Competency assessment dated [DATE] revealed: 7. Remove soiled dressings and discards into appropriate receptacle. 8. Removes gloves, performs hand hygiene, and dons clean gloves. 9. Cleanse the wound as ordered, using gauze once and discard in the appropriate receptacle. 10. Remove gloves, performs hand hygiene, and dons gloves. 2. Review of Resident #45's Quarterly MDS, dated [DATE], reflected resident was a [AGE] year-old male admitted on [DATE] with initial admission on 05/23/2019. Relevant diagnoses included Anemia (not having enough healthy red blood cells or hemoglobin to carry oxygen to body tissues), Coronary Artery Disease (heart disease that affects the main blood vessels that supply blood to the heart), Hypertension (high blood pressure), Peripheral Vascular Disease (condition that reduces blood flow to the arms or legs due buildup of fates, cholesterol and other substances in artery walls), Diabetes Mellitus (metabolic disorder in which the body has high sugars levels for prolonged periods of time), Hyperlipidemia(condition characterized by elevated levels of cholesterol and triglycerides in the blood), Dementia (impaired ability to remember, think or make decisions that interferes with doing everyday activities), Parkinson's disease (progressive disorder that affects the nervous system an causes tremors, stiffness and slow movement), Malnutrition (imbalance of macronutrients), Depression, Dysphagia, oral phase (difficulty with feeding or swallowing involving the mouth, lips and tongue to control food), Need for assistance with personal care, Gastrostomy Status (a tube inserted through the abdomen and into the stomach used for feeding). Review of Resident #45's Quarterly MDS Assessment, dated 08/19/2024, reflected Resident #45 was not able to conduct the BIMS due to Resident #45 was severely cognitively impaired. Resident #45 has a feeding tube while a resident. Observation performed on 09/11/24 at 11:51 AM of LVN D revealed medication administration via peg on Resident #45. Nurse did not sanitize stethoscope before auscultating resident abdomen for peg tube placement or prior to entering the resident's room. During interview on 09/11/24 at 12:05 PM with LVN D regarding not sanitizing of stethoscope. LVN D stated she usually used alcohol wipes but forgot and must have left alcohol wipe under medication tray and should have sanitized stethoscope. She stated they got training on tube feeding procedure about 2-3 times a year, or more frequently if there was any kind of incident and training refreshers on infection control, hand hygiene and enhanced barrier precautions about twice a week. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 09/11/24 at 02:10 PM with the DON revealed nurses get checkoffs upon hire for tube feeding and then annually and any refresher every 6 months. Record Review of the facility's Infection Prevention and Control Program Policy and procedure dated May 13, 2023 revealed Policy Statement: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. 4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. 50532