STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455682	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26244 Based on observation, interview and record review, the facility failed to complete a Significant Change MDS assessment with 14 days after the facility determined, or should have determined, there has been a significant change in a resident's physical or mental condition for 1 of 25 residents reviewed for assessments (Resident # 31). --the facility failed to complete a Significant Change MDS for Resident # 31 within 14 days of the resident's discharge from hospice services. This failure placed residents who had a significant change in condition requiring an MDS assessment at risk of not receiving needed services. Findings included: Record review of Resident #31's face sheet revealed admitted [DATE] with diagnoses including Alzheimer's disease (progressive disease that destroys mental functions), dementia (loss of intellectual functioning), hypertension (high blood pressure), osteoarthritis (joint disease causing tissue breakdown), anxiety disorder (excessive worry or fear), COPD (chronic obstructive pulmonary disease caused by lung damage), Bipolar disorder (mental health condition with extreme mood swings), muscle weakness (decreased muscle strength), abnormal posture (chronic abnormal positions of the body). Record review of documents in Resident #31's clinical chart revealed physician signed admission to hospice services dated 1/31/23. Record review of documents in Resident #31's clinical chart revealed discharge from Hospice services on 3/7/25, due to Resident #31 being medically stable and no longer Hospice appropriate. Interview with Rehab Director on 4/7/25 at 11:50 am revealed Resident #31 is now receiving therapy since she is not on Hospice services any longer. Observation of resident #31 on 4/7/25 at 11:30 am revealed she was in her room in her wheelchair, alert and watching television. She said she was fine and getting ready to go to lunch in a few minutes. She said she had therapy this morning. (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #31's current comprehensive care plan dated 2/12/25 revealed Resident #31 receiving Hospice care, with appropriate interventions. The comprehensive care plan had not been revised to reflect discharge from Hospice services on 3/7/25. Record review of Resident #31's Significant Change MDS dated [DATE] revealed tthe resident was not receiving Hospice services. She was discharged from Hospice services 3/7/25: the Significant Change MDS was completed more than 14 days after the significant change. Interview with MDS nurse A on 4/7/25 at 3:15 pm revealed she just took over this job with MDS and was still learning. She said they just learned this week Resident # 31 was discharged for m hospice services, and she knew the Significant Change MDS should have been done within 14 days. She said she gets information from the nurses about a resident's condition and makes the appropriate changes to MDS if needed. The risk of not having an accurate MDS provided after a significant change of condition would be incorrect information about the resident and inaccurate care provided. Interview with interim DON on 4/7/25 at 4:00 pm revealed the care plans and MDS should be accurate and reflect the resident's true condition, and if they weren't accurate, it would affect the care provided. In further interview, he said the facility followed the RAI manual. A policy on MDS was requested on 4/9/25, and RAI manual guidelines were provided as evidence. Record review of the RAI manual guidelines revealed a Significant Change MDS should be completed 14 calendar days after determination of significant change in status. Record review of the facility policy on MDS revealed dated september, 2020 revealed: .The purpose of this guideline is to provide guidance and instruction on how to complete the RAI process. The RAI process consists of three components: The Minimum Data Set (MDS) Version 3.0, The Care Area Assessment (CAA) process and the RAI utilization guideline. Process The CMS Long-Term Care Facility Resident Assessment User's Manual MDS 3.0 will provide the framework and directions to completing the RAI process All items in the MDS are to be coded per the instructions of the CMS Long-Term Care Facility Assessment User's Manual MDS 3.0 The center will determine who will participate in the assessment process and MDS section responsibility The center will determine how the process in completed ensuring that the process includes direct observation and communication with the residents and direct care staff

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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 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** 26867 Based on interview and record review, the facility failed to ensure all Preadmission Screening and Resident Review (PASARR) Level I (PL1) Screening residents diagnosed with mental illness were provided with a PASARR Level II (PE) Screening for 1 of 3 residents (Resident #48) reviewed for a mental illness, intellectual disability, or developmental disability. The facility failed to ensure Resident #48 who had a diagnosis of mental illness had a PASARR Level II (PE) screening completed. This failure placed residents at risk of mental health needs not being met. The findings included: Resident #48 Record review of Resident #48's face sheet dated 04/09/25 revealed a-[AGE] year-old female admitted to the facility 06/14/23 and readmitted on [DATE]. Her diagnoses included heart diseases, bipolar disorder, schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder), lack of coordination, Anemia, Essential hypertension, cognitive communication deficit., Record review of Resident #48's PASARR Level I (PL1) Screening, dated 06/13/23, indicated Resident #48 was positive for the diagnoses of mental illness. Record review of the Resident #48's annual MDS assessment, dated 05/03/24, revealed her BIMS score was 13 out of 15 indicated she was cognitively intact. Section on active diagnosis revealed she was checked for bipolar disorder and depression and schizophrenia. Record review of Resident #48's Care Plan dated 05/08/24 revealed Resident #48 was care planned for Self-Care Deficit related to: dx Schizophrenia and bipolar. Goal- No functional decline and maintain maximum independence through next review date Initiated: 05/08/2024 Target Date: 01/27/2025. Record review of Resident #48's clinical record revealed no evidence of Level 2 PASRR evaluation for mental illness. During an interview with the facility MDS coordinator on 04/08/25 at 1:00PM, she said she was responsible for completing PASRR for all residents. She said she would look in simple if PASRR level 2 assessment was done because she was not at the facility when the Resident #48's comprehensive assessment was done. (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 04/08/25 at 2:00 PM, MDS Coordinator said PASRR level 2 assessment was not done, and she would revise the MDS and the care plan. She said an inaccurate assessment may delay or prevent Resident from getting the necessary service and care needed to improve their health. Record review of facility provided policy on PASRR revaluation undated titled PASRR Requirements revealed: Guidelines: In effort of the Health Information Management Coordinator to obtain a completed record, all patients must have a Pre-Admission Screening and Resident Review prior to or immediately upon admission as required by Federal and/or a patient/resident specific review process as defined by local State guidelines. The PASRR is completed to determine provision of appropriate and needed serviced to individuals who have been diagnosed with MI/MR. Process: 1. Upon admission a PASRR must be completed timely for patients by qualified individuals. These qualified individuals may include: Physician, Nurse Practitioner, Registered Nurse, Licensed Social Worker or designee. 2. In the event a patient is discharged to a particular hospital with 'return anticipated' and readmitted from that hospital, the original PASRR that was completed at the time of the original admission may be utilized. 3. In the event a patient is discharged to a 'mental health or psychiatric hospital' and returns with a new metal health diagnosis, a new PASRR must be completed prior to or immediately upon readmission. In addition, a Level II must be completed upon or prior to readmission. 4. Each center should follow PASRR and Level II State specific requirements.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care for 1 (Resident #362) of 7 residents reviewed for care plans. The facility failed to develop a baseline care plan, or a comprehensive care plan in place of a baseline care plan, for Resident #362 within 48 hours of admission. The failure could place residents at risk of not receiving effective person-centered care to achieve their highest practicable level of physical, mental, and psychosocial well-being. Findings included: Record review of Resident #362's face sheet dated 4/8/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Acute on Chronic Systolic Heart Failure (disorder where the heart does not pump blood as well as it should), Chronic Kidney Disease (chronic loss of kidney function) and Chronic Obstructive Pulmonary Disease (chronic lung condition causing restricted airflow). Record review of Resident #362's Order Summary Reported dated 4/8/25 revealed order to admit to this skilled nursing facility with order date of 4/4/2025. Record review of Resident #362's Baseline Care Plan - V 8 with effective date of 4/5/25 at 1:35 p.m. revealed no information was completed on the document. Record review of Resident #362's Care Plan printed on 4/8/25 revealed the date initiated for all sections completed was 4/7/25 which was after 48 hours of Resident #362's admission. During interview on 4/9/25 at 11:31 a.m., the DON said the admission nurse was responsible for opening the baseline care plan. During interview on 4/9/25 at 2:49 p.m., LVN Z said LVNs do not open the care plans and a RN should complete the care plan. LVN Z said they did not know which RN was responsible for opening Resident #362's care plan. LVN Z said that there was an RN who came into work at 10 p.m. on 4/4/25 but did not know their name or if they were responsible for opening the care plan. During an interview on 4/9/25 at 2:52 p.m., the DON said that any nurse, a RN or LVN, can open a resident's baseline care plan. Record review of Resident #362's admission MDS dated [DATE] revealed the BIMS section was blank . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's RAI Process Guideline policy dated September 2020 revealed the CMS Long-Term Care Facility Resident Assessment User's Manual MDS 3.0 will provide the framework and directions to completing the RAI process which included the Care Area Assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26244 Based on observation, interview and record review, the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment for 1 of 25 residents reviewed for care plan revision (Resident # 31). --resident #31's comprehensive care plan was not revised to reflect discharge for hospice services. This failure placed residents at risk of not receiving services according to their individual conditions. Findings include: Record review of Resident #31's face sheet revealed admitted [DATE] with diagnoses including Alzheimer's disease (progressive disease that destroys mental functions), dementia (loss of intellectual functioning), hypertension (high blood pressure), osteoarthritis (joint disease causing tissue breakdown), anxiety disorder (excessive worry or fear), COPD (chronic obstructive pulmonary disease caused by lung damage), Bipolar disorder (mental health condition with extreme mood swings), muscle weakness (decreased muscle strength), abnormal posture (chronic abnormal positions of the body). Record review of documents in Resident #31's clinical chart revealed physician signed admission to hospice services dated 1/31/23. Record review of documents in Resident #31's clinical chart revealed discharge from Hospice services on 3/7/25, due to Resident #31 being medically stable and no longer Hospice appropriate. Interview with Rehab Director on 4/7/25 at 11:50 am revealed Resident #31 is now receiving therapy since she is not on Hospice services any longer. Observation of resident #31 on 4/7/25 at 11:30 am revealed she was in her room in her wheelchair, alert and watching television. She said she was fine and getting ready to go to lunch in a few minutes. She said she had therapy this morning and will be having therapy every day now. Record review of Resident #31's comprehensive care plan dated 2/12/25 revealed Resident #31 receiving Hospice care, with appropriate interventions. The comprehensive care plan had not been revised to reflect discharge from Hospice services on 3/7/25. Interview with MDS nurse A on 4/7/25 at 3:15 pm revealed she just took over this job with MDS and was still learning. She said they did not know Resident #31 had been discharged from Hospice services until this week. She said she would get information from the nurses about a resident's condition and make the appropriate changes to care plans if needed. She said the MDS nurse would update the care plans from information from the nurses who would tell them of any changes, or at the IDT meeting. The risk of not having accurate care plans would be not the right care provided. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with interim DON on 4/7/25 at 4:00 pm revealed the care plans should be accurate and reflect the resident's true condition, and if care plans weren't accurate, it would affect the care provided. In further interview, he said the facility followed the RAI manual. A policy on care plans was requested on 4/9/25, but not supplied by the time of exit. The policy on the RAI manual was given as evidence for care plan accuracy. Record review of the facility policy on care planning dated September 2020 revealed : .The purpose of this guideline is to provide guidance and instruction on how to complete the RAI process. The RAI process consists of three components: The Minimum Data Set (MDS) Version 3.0, The Care Area Assessment (CAA) process and the RAI utilization guideline. Process ? The CMS Long-Term Care Facility Resident Assessment User's Manual MDS 3.0 will provide the framework and directions to completing the RAI process ? All items in the MDS are to be coded per the instructions of the CMS Long-Term Care Facility Assessment User's Manual MDS 3.0 ? The center will determine who will participate in the assessment process and MDS section responsibility ? The center will determine how the process in completed ensuring that the process includes direct observation and communication with the residents and direct care staff

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036 Based on observation, interview and record review, the facility failed to ensure that all drugs and biologicals used in the facility must include the expiration date when applicable and were not expired for two (100 Hallway medication aide medication cart and 400 Hallway nurse medication cart) out of three medication carts reviewed for medication storage and labeling. 1. The facility failed to ensure that Latanoprost eye drops (Latanoprost is used to treat certain types of Glaucoma and other causes of high pressure inside the eye) were labeled with expiration date for Resident #32, Resident #35, and Resident #88. 2. The facility failed to ensure that Latanoprost eye drops (Latanoprost is used to treat certain types of Glaucoma and other causes of high pressure inside the eye) was removed from the medication cart for Resident #28 as it was past its use by recommendation. 3. The facility failed to ensure that Humalog KwikPen/insulin lispro (insulin which is a medication that lowers blood sugar) for Resident #39 was dated with open date when it was removed from the medication refrigerator and placed on the medication cart as Humalog KwikPens are only recommended to be used for 28 days once removed from the refrigerator. This failure could place residents at risk of not receiving the intended therapeutic effects of prescribed medications or receiving potentially harmful side effects from prescribed medications. Findings included: Record Review of Resident #28's face sheet dated [DATE], revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Unspecified Dementia (group of symptoms affecting memory, thinking and social abilities) and Type 2 Diabetes Mellitus (high blood sugar). Record review of Resident's #28's quarterly MDS dated [DATE] revealed a BIMS score of 15 that suggested cognition was intact. Record Review of Resident #32's face sheet dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Primary Generalized (Osteo)Arthritis (breakdown of tissues of joints) and Absolute Glaucoma (eye condition that damages the optic nerve). Record review of Resident's #32's quarterly MDS dated [DATE] revealed a BIMS score of 15 that suggested cognition was intact (,d+[DATE]). Record review of Resident #32's Care Plan printed [DATE] revealed Administer eye drops for glaucoma as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #32's Order Summary Report dated [DATE] revealed Latanoprost Ophthalmic Solution 0.005% with instructions to instill 1 drop in both eyes at bedtime. Record Review of Resident #35's face sheet dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Anemia (low red blood cells) in Chronic Kidney Disease and Glaucoma in Diseases Classified Elsewhere (eye condition that damages the optic nerve). Record review of Resident's #35's annual MDS dated [DATE] revealed a BIMS score of 10 that suggested moderate cognitive impairment. Record review of Resident #35's Order Summary Report dated [DATE] revealed Latanoprost Ophthalmic Solution 0.005% with instructions to instill 1 drop in both eyes at bedtime. Record Review of Resident #39's face sheet dated [DATE], revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Osteomyelitis (bone infection and Type 2 Diabetes Mellitus (high blood sugar) with Foot Ulcer (wound). Record review of Resident's #39's quarterly MDS dated [DATE] revealed a BIMS score of 13 that suggested cognition was intact (,d+[DATE]). Record review of Resident #39's Care Plan printed [DATE] revealed Diabetes medication as ordered by doctor. Record review of Resident #39's Order Summary Report dated [DATE] revealed Insulin Lispro Injection Solution 100 unit/milliliter with instructions to inject 8 units under the skin three times a day with meals if blood sugar is greater than 300. Record Review of Resident #88's face sheet dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Nontraumatic Chronic Subdural Hemorrhage (brain bleed) and Unspecified Glaucoma (eye condition that damages the optic nerve). Record review of Resident's #88's quarterly MDS dated [DATE] revealed a BIMS score of 14 that suggested cognition was intact. Record review of Resident #88's Order Summary Reported dated [DATE] revealed Latanoprost Ophthalmic Solution 0.005% with instructions to instill 1 drop in both eyes one time a day. Record review of Instructions For Use Humalog KwikPen revised ,d+[DATE] revealed unused Humalog KwikPen should be stored in the refrigerator at 36 to 46 degrees Fahrenheit. Record review also revealed to store in use Humalog KwikPen at room temperature and to throw the Humalog KwikPen away after 28 days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 10:15 a.m. of 100 Hallway medication aide medication cart revealed Latanoprost 0.005% ophthalmic (eye) solution for Resident #28 was dated [DATE] and the label for the Latanoprost had instructions to discard the medications after six weeks which was [DATE]. Observation also revealed no open dates documented for two bottles of Latanoprost 0.005% ophthalmic (eye) solution for Resident #32, Latanoprost 0.005% ophthalmic (eye) solution for Resident #88, Latanoprost 0.005% ophthalmic (eye) solution for Resident #35. Observation on [DATE] at 10:49 a.m. of 400 Hallway nurse medication cart revealed undated Humalog Kwik Pen for Resident #39. During interview on [DATE] at 9:25 a.m., the ADON said they started at the facility on [DATE] and they were going to work on reviewing the medication carts. During the interview on [DATE] at 11:31 a.m., the DON said that whoever used the medication cart was responsible for the medication cart and the managers should audit the medication carts as well . During interview on [DATE] at 1:51 p.m., the Pharmacist said they look at two random medication carts at the facility. The Pharmacist said they look for expiration dates, open dates and that medications are separated by route. Record review of facility's Storage of Medication policy with effective date of [DATE] revealed outdated, contaminated, or deteriorated mediation are immediately removed from inventory. It was also revealed When the manufacturer has specified a usable duration after opening (i.e. beyond use date), the nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration.

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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** 51036 Based on interview and record review, the facility failed to ensure any drug regimen irregularities were accurately reported by the Pharmacist Consultant for 1 (Resident #90) of 7 residents reviewed for pharmacy services. The facility failed to ensure that Resident #90 did not have duplicate medication orders. The failure could place residents at risk of receiving inaccurate administration of medications which could result in possible adverse effects or residents not receiving therapeutic benefits of medications. Findings included: Record Review of Resident #90's face sheet dated 4/9/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Quadriplegia (inability to move all four limbs) and Generalized Anxiety Disorder. Record review of Resident #90's quarterly MDS dated [DATE] revealed a BIMS score of 12 that suggested moderate cognitive impairment. Record review of Resident #90's Order Summary Report dated 4/9/2025 at 8:38 a.m. revealed order for Buspirone 5 mg with instructions to give 1 tablet by mouth two times a day with start date of 1/23/2025 with no end date. Record review also revealed an order for Buspirone 5 mg to give 1 tablet by mouth three times a day with start date of 3/1/25 with no end date. Record review of Resident #90's March MAR printed 4/9/24 revealed Buspirone 5 mg with instructions to give 1 tablet by mouth two times a day with administrations being documented from 3/1-3/31/25 and Buspirone 5 mg with instructions to give 1 tablet by mouth three times a day with administrations being documented from 3/3-3/31/25. Record review of Resident #90's April MAR printed 4/9/25 revealed Buspirone 5 mg with instructions give 1 tablet by mouth two times a day as being administered from 4/1-4/8/25 and Buspirone 5 mg with instructions give 1 table by mouth three times a day being administered from 4/1-4/8/25 except for 4/8/25 at 1 p.m. for which there was no documentation. Record review of Resident #90's Care Plan printed 4/9/25 revealed intervention Administer medications as ordered. Record review of nursing Progress Notes dated 4/9/25 at 3:46 p.m. revealed that LPN Y documented Call placed to MD to clarify buspirone orders awaiting return call. Record review of Resident #90's electronic medication record revealed that Buspirone 5 mg with instructions give 1 table two times a day was discontinued on 4/9/2025 at 10:32 a.m. ordered by Dr. G. (continued on next page)

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	455682	A. Building B. Wing	04/09/2025

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Afton Oaks Nursing Center	7514 Kingsley St Houston, TX 77087

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations for Recommendation Created Between 3/1/2025 and 3/19/2025 dated 3/19/2025 revealed that Resident #90 was listed as being reviewed but did not require any recommendations. Record review of Psychotropic & Sedative/Hypnotic Utilization by Resident For Records Updated Between 3/1/2025 And 3/19/2025 revealed Buspirone Hydrochloride (Buspirone Hcl Tab 5 mg) 1 three times a day with order date of 1/23/2025. During an interview on 4/9/25 at 8:57 a.m., LPN Y said the doctor should have discontinued the previous Buspirone order for Resident #90 when the new order was entered. During an interview on 4/9/25 at 9:01 a.m., MA L said the Buspirone order for Resident #90 was a duplicate. MA L said Resident #90 received Buspirone in the morning, at 1 p.m. and at night. MA L said that she usually worked the 400 hallway where the resident was located and has worked at the facility since October of 2023. MA L said she received in-services from the facility especially regarding medication errors and that she received in-services at least monthly and maybe every two weeks. MA L said that the pharmacist came to the facility on Thursdays and did trainings as well. MA L said that a negative effect if a resident received a medication that was not accurate that it would be a medication error and the resident could have received a double dose. During observation and interview on 4/9/25 at 9:10 a.m. revealed that Resident #90 was lying in hospital bed. Resident #90 was alert and no signs of distress noted. Resident #90 did not mention any concerns regarding his Buspirone when he was asked if he had any issues regarding his medications. During interview on 4/9/25 at 9:19 a.m., LPN Y said they notified Dr. G regarding the Buspirone order, and that Dr. G said that they would fix the order. LPN Y said they had worked at the facility for six months and had not received any ongoing training from the facility regarding medications. LPN Y said that an adverse reaction if a resident received a medication that was not accurate would be the resident would need to be monitored and would be a medication error. During interview on 4/9/25 at 9:25 a.m., the ADON said they started at the facility on 4/7/25. The ADON said they were not familiar with the facility's process of reviewing new orders. The ADON said that the process they were familiar with was that the managers have morning meetings to review orders and if this was not the current process then they would recommend this. The ADON said an adverse effect a resident could have if not given the accurate dosage of medication was adverse side effects depending on the medication. During interview on 4/9/25 at 9:31 a.m., the DON said previous orders should be discontinued when new orders are put in. Regarding the Buspirone order for Resident #90 with start date of 3/1/25, the DON said that it looked like the doctor put a new order in but did not discontinue the previous order. The DON said the pharmacy reviewed the medications monthly for residents and had not yet reviewed medications for April. The DON said an adverse effect a resident could experience receiving a medication incorrectly would depend on the medication, but the resident could have an adverse reaction. During interview on 4/9/25 at 9:46 a.m., the Administrator said orders should be reviewed daily for accuracy. The Administrator said that there was a daily clinical startup which was a clinical meeting in the mornings that the DON, unit managers and reimbursement nurses attended and reviewed new orders. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Message left by surveyor for Dr. G on 4/9/25 at 11:23 a.m. with request to call surveyor but no call back received prior to survey exit. During interview on 4/9/25 at 1:51 p.m., the Pharmacist said they only had Buspirone three times a day documented for Resident #90 in her notes which was separate from the facility's electronic medical record and denied having any notes regarding Resident #90 taking Buspirone twice a day. The Pharmacist said that she looks for duplicate medication entries when reviewing medication orders. The Pharmacist said that they review the medications a few days before they come to the facility. Record review of facility's Clinical Start-Up Guide: A Qualitative Audit policy revealed that during the Clinical Start-Up that new physician orders are viewed for accuracy of transcription of physician's orders into the electronic medical record.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036 Based on interview and record review, the facility failed to ensure any medications were not given in excessive doses for 1 (Resident #90) of 7 residents reviewed for medication orders. The facility failed to ensure that Resident #90 did not recieve incorrect doses of medication. The failure could place residents at risk of receiving inaccurate administration of medications which could result in possible adverse effects or residents not receiving therapeutic benefits of medications. Findings included: Record Review of Resident #90's face sheet dated 4/9/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Quadriplegia (inability to move all four limbs) and Generalized Anxiety Disorder. Record review of Resident #90's quarterly MDS dated [DATE] revealed a BIMS score of 12 that suggested moderate cognitive impairment. Record review of Resident #90's Order Summary Report dated 4/9/2025 at 8:38 a.m. revealed order for Buspirone 5 mg with instructions to give 1 tablet by mouth two times a day with start date of 1/23/2025 with no end date. Record review also revealed an order for Buspirone 5 mg to give 1 tablet by mouth three times a day with start date of 3/1/25 with no end date. Record review of Resident #90's March MAR printed 4/9/24 revealed Buspirone 5 mg with instructions to give 1 tablet by mouth two times a day with administrations being documented from 3/1-3/31/25 and Buspirone 5 mg with instructions to give 1 tablet by mouth three times a day with administrations being documented from 3/3-3/31/25. Record review of Resident #90's April MAR printed 4/9/25 revealed Buspirone 5 mg with instructions give 1 tablet by mouth two times a day as being administered from 4/1-4/8/25 and Buspirone 5 mg with instructions give 1 table by mouth three times a day being administered from 4/1-4/8/25 except for 4/8/25 at 1 p.m. for which there was no documentation. Record review of Resident #90's Care Plan printed 4/9/25 revealed intervention Administer medications as ordered. Record review of nursing Progress Notes dated 4/9/25 at 3:46 p.m. revealed that LPN Y documented Call placed to MD to clarify buspirone orders awaiting return call. Record review of Resident #90's electronic medication record revealed that Buspirone 5 mg with instructions give 1 table two times a day was discontinued on 4/9/2025 at 10:32 a.m. ordered by Dr. G. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Psychotropic & Sedative/Hypnotic Utilization by Resident For Records Updated Between 3/1/2025 And 3/19/2025 revealed Buspirone Hydrochloride (Buspirone Hcl Tab 5 mg) 1 three times a day with order date of 1/23/2025. During an interview on 4/9/25 at 8:57 a.m., LPN Y said the doctor should have discontinued the previous Buspirone order for Resident #90 when the new order was entered. During an interview on 4/9/25 at 9:01 a.m., MA L said the Buspirone order for Resident #90 was a duplicate. MA L said Resident #90 received Buspirone in the morning, at 1 p.m. and at night. MA L said that she usually worked the 400 hallway where the resident was located and has worked at the facility since October of 2023. MA L said she received in-services from the facility especially regarding medication errors and that she received in-services at least monthly and maybe every two weeks. MA L said that a negative effect if a resident received a medication that was not accurate that it would be a medication error and the resident could have received a double dose. During observation and interview on 4/9/25 at 9:10 a.m. revealed that Resident #90 was lying in hospital bed. Resident #90 was alert and no signs of distress noted. Resident #90 did not mention any concerns regarding his Buspirone when he was asked if he had any issues regarding his medications. During interview on 4/9/25 at 9:25 a.m., the ADON said they started at the facility on 4/7/25. The ADON said they were not familiar with the facility's process of reviewing new orders. The ADON said that the process they were familiar with was that the managers have morning meetings to review orders and if this was not the current process then they would recommend this. The ADON said an adverse effect a resident could have if not given the accurate dosage of medication was adverse side effects depending on the medication. During interview on 4/9/25 at 9:31 a.m., the DON said previous orders should be discontinued when new orders are put in. Regarding the Buspirone order for Resident #90 with start date of 3/1/25, the DON said that it looked like the doctor put a new order in but did not discontinue the previous order. The DON said an adverse effect a resident could experience receiving a medication incorrectly would depend on the medication, but the resident could have an adverse reaction. During interview on 4/9/25 at 9:46 a.m., the Administrator said orders should be reviewed daily for accuracy. The Administrator said that there was a daily clinical startup which was a clinical meeting in the mornings that the DON, unit managers and reimbursement nurses attended and reviewed new orders. Message left by surveyor for Dr. G on 4/9/25 at 11:23 a.m. with request to call surveyor but no call back received prior to survey exit. Record review of facility's Clinical Start-Up Guide: A Qualitative Audit policy revealed that during the Clinical Start-Up that new physician orders are viewed for accuracy of transcription of physician's orders into the electronic medical record.

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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** 26867 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: 1.The facility failed to keep the dining room clean and free of dirty dishes with leftover food overnight 2.The facility failed to ensure that the rails along the vent hood was free of grease. 3. The facility failed to store and date foods stored in the refrigerator one of two refrigerator in the kitchen. 3. The facility failed to ensure that the dry good pantry was free from expired food product. These failures could place residents at risk for food borne illness. The findings included: Observation of the dining room on [DATE] at 6:50 AM revealed- -Observation of the dining room revealed there were 5 Resident sitting in the dining room waiting for their coffee. Observation of the door by the dish washing machine, revealed a small cart in the dining room with leftover food, and gnats flying around the dishes. -Observation and interview on [DATE] beginning at 6:50AM, revealed there were grease build up along the vent hood rails. Observation of one of 2 freezer in the kitchen (Freezer #2) in the main kitchen, revealed the following- -large bowl of salad undated and unlabeled (no identifying information). [NAME] K said that was left over from Yesterday [DATE]. -Fruit (Peaches) out of original container in a plastic container unlabeled and undated -Tuna salad in a large bowl covered with plastic wrap dated 03\30\25 to use by 04\06\25. -Observation of one of two freezers at the back revealed 6 individual cookies in plastic -wrap dated [DATE]. [NAME] K took them out and said, what are these and toss them in a trash container. -observation of the dry goods area revealed 5lbs container of creamy peanut butter dated best used by 03\23\23. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All unlabeled and undated food items were identified by [NAME] K. During an interview with [NAME] K on [DATE] at 7:15AM, she said she was off over the weekend. She said the vent hood was supposed to have been cleaned and all food in the freezer and the refrigerator should be labeled and dated with date opened and used by date. During an interview with the Dietary Manager on [DATE] at 7:30AM, he said the vent hood was supposed to have been cleaned. He said he will get it done. He looked at the dirty dishes in the dining room by the dishwashing room and said they might have been brought to the dining room after the kitchen was closed. He said all food items out of the original container are supposed to be dated and labeled with the date opened and used by date. He said all staff are responsible for cleaning after themselves and whoever put leftover food items in the refrigerator\freezer was supposed to have date when opened\left over date and use by date. Record review of facility police dated ,d+[DATE] revised ,d+[DATE] titled Food: Preparation revealed in part Policy Statement: Policy Statement All foods are prepared in accordance with the FDA Food Code Food Storage: Dry Goods Policy Statement All dry goods will be appropriately stored will be appropriately stored in accordance with the FDA Food Code. Environment: Policy Statement All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.