STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 7 residents reviewed for medications. (Resident #1) The facility failed to ensure: 1. Resident #1 was administered his regular evening medication as ordered along with Resident #2's evening medication on the evening of 5/5/2025. Resident #1's medication included Gabapentin 200 mg at bedtime (a medication used to treat peripheral neuropathy, chronic pain) Hemp gummies 20,000 2 gummies at bedtime (a supplement used to treat anxiety, depression, pain, inflammation and improve sleep), Melatonin 9 mg at bedtime (a supplement to assist in sleep), Tamsulosin 0.4 mg at bedtime (a medication used to treat an enlarged prostate), Docusate Sodium 100 mg twice daily (a stool softener), Eliquis 5 mg every 12 hours (a blood thinner), Furosemide 40 mg twice daily (a medication used to treat fluid), Metoprolol 50 mg twice daily and acetaminophen-codeine 300-60 mg three times daily. 2. Resident #2's medications was administered to Resident #1 on 5/5/2025 which included clobazam 20 mg 1 tablet twice daily (a medication used to treat seizures), diazepam 5 mg 1 tablet twice daily (a medication used to treat seizures), Docusate sodium 100 mg 1 capsule twice daily (a stool softener used to treat constipation), Keppra 1000 mg twice daily (a medication used to treat seizures), lamotrigine 200 mg 1 tablet three times daily (a medication used to treat seizures), Metformin 500 mg 1 tablet twice daily (a medication used to treat diabetes), Mirtazapine 15 mg 1 tablet at bedtime (a medication used to treat depression), Singular 10 mg 1 tablet at bedtime (a medication used to treat allergies), Topamax 200 mg 1 tablet twice daily (a medication used to treat seizures), and Trazadone 50 mg 1 tablet at bedtime (a medication to treat insomnia). 3. Resident #1's orders indicated he had an allergy to Trazodone with documented reaction indicating an intolerance and reaction manifestation of altered mental status. An Immediate Jeopardy (IJ) was identified on 5/15/2025 at 9:30 AM. The IJ template was provided to the facility on [DATE] at 10:03 AM. While the IJ was removed on 5/16/2025 the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These deficient practices could place residents at risk of physical complications, hospitalization , and possible death. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings included: Record of Resident #1's face sheet dated 5/14/2025 indicated he was an [AGE] year-old male readmitted to the facility on [DATE]. Resident #1's diagnosis included COPD (a group of lung diseases that block airflow and make it difficult to breathe), transient cerebral ischemic attack (a brief stroke-like attack that despite resolving within minutes to hours, requires immediate medical attention), acute and chronic respiratory failure (a condition where the lungs are unable to adequately transfer oxygen into the blood, leading to low oxygen levels in the body), benign prostatic hyperplasia with lower urinary tract symptoms (an enlarged prostate gland which can put pressure on the urethra and cause urinary symptoms), and dementia (a group of thinking and social symptoms that interferes with daily functioning). Record review of an annual MDS assessment, dated 1/14/2025, indicated Resident #1 was understood and understood others. The MDS indicated Resident #1 had a BIMS score of 13 which indicated he was cognitively intact, and he required partial assistance with oral hygiene, dressing upper body, and dressing lower body. Resident #1 required maximal assistance with bathing and was dependent with toileting and putting on and taking off footwear. Record review of Resident #1's care plan revised on 1/29/2025 indicated ADL self-care performance deficits related to fatigue, COPD and recurrent pneumonia. Some of the interventions included level of assistance may vary slightly from day to day. OT started on 4/3/2025 and completed on 4/18/2025 related to muscle wasting and pain to right hand. The resident required assistance from staff for bathing and required extensive assistance for bed mobility. Resident #1 had a decreased cognitive function/memory impairment related to his diagnosis of Dementia. Some interventions included to administer medications as ordered. Monitor and document for side effects and effectiveness, ask yes/no questions to determine the resident's needs, cue, reorient and supervise as needed, and keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion. Record review of Resident #1's order summary report dated 5/13/2025 indicated Resident #1 was prescribed the following evening medications: Gabapentin 200 mg at bedtime (a medication used to treat peripheral neuropathy, chronic pain) Hemp gummies 20,000 2 gummies at bedtime (a supplement used to treat anxiety, depression, pain, inflammation and improve sleep), Melatonin 9 mg at bedtime (a supplement to assist in sleep), Tamsulosin 0.4 mg at bedtime (a medication used to treat an enlarged prostate), Docusate Sodium 100 mg twice daily (a stool softener), Eliquis 5 mg every 12 hours (a blood thinner), Furosemide 40 mg twice daily (a medication used to treat fluid), Metoprolol 50 mg twice daily and acetaminophen-codeine 300-60 mg three times daily. Resident #1 had orders for side effect monitoring for antidepressants. Resident #1 did not have any new orders for vital signs or neuro checks ordered. Record review of Resident #1's TAR dated 5/1/2025-5/31/2025 indicated Resident #1's behavioral monitoring for side effects of antidepressants did not indicate by O- None that Resident was experiencing any side effects of his medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's MAR dated 5/1/2025-5/31/2025 indicated Resident #1 was administered his evening medication which included Gabapentin 200 mg at bedtime (a medication used to treat peripheral neuropathy, chronic pain) Hemp gummies 20,000 2 gummies at bedtime (a supplement used to treat anxiety, depression, pain, inflammation and improve sleep), Melatonin 9 mg at bedtime (a supplement to assist in sleep), Tamsulosin 0.4 mg at bedtime (a medication used to treat an enlarged prostate), Docusate Sodium 100 mg twice daily (a stool softener), Eliquis 5 mg every 12 hours (a blood thinner), Furosemide 40 mg twice daily (a medication used to treat fluid), Metoprolol 50 mg twice daily and acetaminophen-codeine 300-60 mg three times daily. Record review of Resident #1's progress note dated 5/5/2025 at 8:45 PM, LVN A noted Resident #1 was inadvertently given the wrong medications. LVN A noted vital signs were taken, resident was alert and answering appropriate questions at this time. LVN A documented the NP was notified and orders were received to check neuros every 30 minutes for 4 hours and then every hour throughout the shift. The progress note indicated to refer to neuro notes and oxygen saturation notes and the DON was notified. Record review of Resident #2's order summary report dated 5/16/2025 indicated Resident #2's evening medications were clobazam 20 mg 1 tablet twice daily (a medication used to treat seizures), diazepam 5 mg 1 tablet twice daily (a medication used to treat seizures), Docusate sodium 100 mg 1 capsule twice daily (a stool softener used to treat constipation), Keppra 1000 mg twice daily (a medication used to treat seizures), lamotrigine 200 mg 1 tablet three times daily (a medication used to treat seizures), Metformin 500 mg 1 tablet twice daily (a medication used to treat diabetes), Mirtazapine 15 mg 1 tablet at bedtime (a medication used to treat depression), Singular 10 mg 1 tablet at bedtime (a medication used to treat allergies), Topamax 200 mg 1 tablet twice daily (a medication used to treat seizures), and Trazadone 50 mg 1 tablet at bedtime (a medication to treat insomnia). These medications were administered to Resident #1 on 5/5/2025. Record Review of an allergy alert dated 6/24/2024, indicated Resident #1 had an allergy to Trazodone with a reaction manifestation noted altered mental status. Record review of neurological assessment dated [DATE] at 8:45 PM, LVN A noted Resident #1 did not refuse neuro checks. She indicated his blood pressure was 109/50, pulse 96, respirations 18 and temperature 97.9. The neurological assessment indicated Resident #1 was alert, hand grasp was equal, he moved all extremities, his pupils were equal and reactive to light. LVN A documented Resident # 1's right and left pupils were dilated and responded appropriately to pain. Record review of neurological assessment dated [DATE] at 9:15 PM, LVN A noted Resident #1 did not refuse neuro checks. She documented NA for the blood pressure, pulse, respirations, and temperature indicating the vital signs were not assessed. The neurological assessment indicated Resident #1 was alert, hand grasp was equal, he moved all extremities, his pupils were equal and reactive to light. LVN A documented Resident # 1's right and left pupils were dilated and there was no response to pain. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of neurological assessment dated [DATE] at 10:45 PM, LVN A noted Resident #1 did not refuse neuro checks. She documented NA for the blood pressure, pulse, respirations, and temperature indicating the vital signs were not assessed. The neurological assessment indicated Resident #1 was lethargic/drowsy, hand grasp was equal, he moved all extremities, his pupils were not equal and reactive to light. LVN A documented Resident # 1's right and left pupils were sluggish and Resident #1 response to pain was appropriate. Record review of Resident #1's progress note dated 5/5/2025 at 11:00 PM, Resident #1 was awake and trying to get out of bed, wanted something to eat. He wanted a can of Vienna [NAME] and ate them all. Resident #1 then wanted pizza he had left and ate it all. LVN A indicated Resident #1 continues to be drowsy but alert and appeared too sleepy to open eyes. Record review of neurological assessment dated [DATE] at 11:45 PM, LVN A indicated Resident #1 did not refuse neuro checks. She indicated his blood pressure was 124/75, pulse 113, respirations 18 and no temperature was taken. The neurological assessment indicated Resident #1's level of consciousness was lethargic/drowsy, hand grasp was equal, moved all extremities, pupils were not equal or reactive to light, right and left pupil were sluggish, and Resident #1 responded appropriately to pain. Record review of neurological assessment dated [DATE] at 12:15 AM, LVN A indicated Resident #1 did not refuse neuro checks. She indicated NA on his blood pressure, pulse, respirations, and temperature indicating vital signs were not obtained. LVN A noted Resident #1's level of consciousness was lethargic/drowsy, hand grasp was equal, moved all extremities, pupils were not equal or reactive to light, right and left pupils were sluggish, and Resident #1 responded appropriately to pain. Record review of neurological assessment dated [DATE] at 12:45 AM, LVN A indicated Resident #1 did not refuse neuro checks. She indicated NA on his blood pressure, pulse, respirations, and temperature indicating vital signs were not obtained. LVN A noted Resident #1's level of consciousness was alert, hand grasp was equal, he moved all extremities, pupils were not equal and reactive to light, right and left pupil were sluggish, and Resident #1 responded appropriately to pain. Record review of a neurological assessment dated [DATE] at 1:45 AM indicated Resident #1 refused neuro checks. Record review of Resident #1's progress note dated 5/6/2025 at 1:45 AM, LVN A indicated Resident #1 would not open his eyes when nurse asked him to open his eyes but did shake his head no. LVN A noted she had been able to obtain oxygen saturations and the readings were in the high 90's. Record review of a neurological assessment dated [DATE] at 2:45 AM indicated Resident #1 refused neuro checks. Record review of a neurological assessment dated [DATE] at 3:45 AM indicated Resident #1 refused neuro checks. Record review of a neurological assessment dated [DATE] at 4:45 AM indicated Resident #1 refused neuro checks. Record review of a neurological assessment dated [DATE] at 5:45 AM indicated Resident #1 refused neuro checks. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Physician Progress note dated 5/7/2025 at 11:15 AM indicated Resident #1 was out of room in his wheelchair. The Pain Management NP documented Resident #1 required full assist with transfers and ADL's. The progress note indicated Resident #1 was prescribed Tylenol #4 every 4 to 6 hours as needed but because of increased pain on April 13, the dose was changed to Tylenol #4 scheduled 3 times a day and every 6 hours as needed for rescue pain treatment. The progress note indicated Resident #1 had no adverse effects from medications and was pleasant. He indicated Resident #1 had an allergy to Trazodone. The Pain Management NP's progress note indicated Resident #1 reported fatigue and arthralgia/joint pain. The progress note indicated Resident #1 was oriented to self, place, and time and his affect was appropriate. During an interview on 5/14/2025 at 1:33 PM, LVN A said she worked at the facility part-time. LVN A said she had gone into Resident #1 and Resident #2's room while holding Resident #2's evening medications. She said Resident #1 was wanting a breathing treatment and she handed him Resident #2's medications and he took them. She said she realized what she had done and call the NP. LVN A said Resident #1 acted drunk and was slurring his words after taking the medications. She said Resident #1 was fine when she left. LVN A said she had notified Interim DON T and the Physician. LVN A said the NP instructed her to check Resident #1's vital signs every 30 minutes for 4 hours and then hourly. She said she was also instructed to complete neuro checks and oxygen saturations. LVN A said Resident #1 was getting upset and not letting her check his vital signs. LVN A said she could not recall the medications that were administered to Resident #1. LVN A said she completed a risk management form and completed the medication error form that populates in the EMR. LVN A said she did not recall completing an incident report. LVN A said Resident #1 received all of Resident #2's evening medications. LVN A said she could not recall if she checked to see if Resident #1 had any allergies to Resident #2's medications. LVN A said Resident #1 could have an adverse reaction and she could not recall if Trazadone was one of the medications she administered. LVN A said whatever was on Resident #2's MAR for the evening was what Resident #1 had received. During an interview on 5/14/2025 at 2:05 PM, LVN B said Resident #1 was transported to the hospital on 5/13/2025. LVN B said Resident #1 was bedbound and navigated the facility in his electric scooter. LVN B said Resident #1 was normally awake, alert, and oriented to person, place, time, and situation. LVN B said Resident #1 was sometimes confused. LVN B said the normal process to reporting an incident such as falls, or medication errors required the nurse to complete a form under risk management on the EMR. She said the first thing she would need to do would be to contact the Physician, DON, Supervisor, and family. She said then the nurse would need to write up an incident and document when it occurred. LVN B said the DON and ADM should investigate the issue and follow up. During an interview on 5/14/2025 at 2:33 PM, the RP said Resident #1 was currently in the hospital. He stated Resident #1 had not been the same since he was administered the wrong medication and stated he had gone downhill. RP said the medication that he took caused a reaction. RP said Resident #1 was taken by ambulance and he stayed in the ER for a while until he was stable. RP said Resident #1 was currently on oxygen and was in and out mentally. RP said he could hardly hear him when he talked, and Resident #1 does not know who he is. RP said it was from his understanding the medication was administered to him on Monday night. He said when the facility called, they told him Resident #1 was having an episode. Rp said he did not find out about the nurse administering the wrong medication until the next day. RP said the NP did not send Resident #1 out the day the medication was administered. RP said Resident #1 was currently in ICU. RP said the facility would not tell him what medications were administered. RP said Resident #1 had COPD and it had been controlled. RP said he was not sure if Resident #1 had any allergies. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 5/14/2025 at 3:02 PM, the NP said he was called about the medication error last week. He said the nurse had informed him she had administered Resident #1 the wrong medications. He said he was told the medications were Tegretol, Keppra and Metformin. He said he had asked her if she had administered the 5 rights of medication administration and she said no. He advised her to monitor the resident and he called the Physician to consult. NP said he was going to instruct the nurse to monitor Resident #1 every hour but changed it to every 30 minutes after discussing with the DON. NP said he did not assess Resident #1 on Thursday when he was at the facility because he saw him up and about. The NP said the main side effect could be sedation. The NP said with all the medications administered, it could affect the residents breathing. The NP said he did not feel the medication error could have caused Resident #1 to have pneumonia. During an interview on 5/14/2025 at 3:14 PM, the Interim DON U said Resident #1 was sent to the hospital because his eyes rolled back. Interim DON U said if there was a medication error, it would be entered by the nurse and brought to the charge nurse, ADON, DON and ADM. He said the physician and family would have been made aware. Interim DON U said there was an incident report in the computer, but it did not list the medications that were administered. Interim DON U said he would have listed the medications administered. Interim DON U said he would expect the orders to be in the computer but could not locate the neurological assessment orders or the vital sign orders. Interim DON U said medications administered to Resident #1 could cause an allergic reaction or adverse effect depending on the medication. He said Resident #1 could have respiratory issues or become too sleepy. Interim DON U said a resident with COPD can increase the risk with many medications. He said Resident #1 remained in the hospital. During an interview on 5/15/2025 at 7:35 AM, the ADON said the Interim DON T at the time was notified and the NP had called her. The ADON said the NP was upset. The ADON said the NP instructed staff to monitor Resident #1 until the next day. The ADON said the pain management provider came in and noticed Resident #1 was drowsy and wanted to adjust his pain medications. The ADON said she explained to the NP what had happened, and Resident #1 was not sedated from the pain medication but was administered the wrong medications. The ADON said Resident #1 was up in his wheelchair the next day and was doing fine. She said Resident #1 was ordered to have every 4-hour vital sign and neuro checks, but Interim DON T had advised vital signs to be checked more frequently. The ADON said there would not need to be an order written. The ADON said she would expect the nurse to have documented the vital signs in the computer. The ADON said the Interim DON T did not complete an investigation. The ADON said if the resident did not have a good renal function, it could have been bad. She said the medications administered to Resident #1 could have suppressed his respirations. The ADON said she was not aware Resident #1 had his evening medications as scheduled and the nurse did not tell the resident had any allergies. The ADON said she had provided the nurse a verbal in-service on the 7 Rights of Medication Administration. During an interview on 5/15/2025 at 9:01 AM, the NP said he had spoken with the Interim DON T and discussed she wanted the vital signs and neuro checks to be completed every 30 minutes. He said he would not have done anything differently if he had known Resident #1 was allergic to Trazadone. He said if Resident #1 was to have an allergic reaction, he would have advised the nurse to administer the resident a Benadryl and to call 911. He said it would have been nice to know the resident had slurred speech and was drowsy but that would be expected with the medications he was administered. The NP said it did not surprise him that the vital signs were not taken as he had ordered . He said the pain management NP came in the next day and assessed the resident and said he was fine. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/15/2025 at 1:30 PM, the Regional [NAME] President provided additional information. He said he provided the neurological assessment with vital signs that were documented on 5/5/2025. He said the vital signs were documented on the neurological assessment form and not in the computer. He said LVN A did not document in her charting Resident #1 was slurring his words or acting drunk. He said Resident #1 took CBD gummies and would be lethargic at bedtime. The Regional [NAME] President said one of the progress notes indicated Resident #1 woke up asking for food and it was provided to him. The Regional [NAME] President felt Resident #1 was alert enough to ask for food. He said he spoke with the Corporate Nurse, and she said the orders for neuro checks was fine in the progress note and a written order would not be necessary. The Regional [NAME] President reviewed neuro checks and acknowledged there was only 2 vital sign checks on the neuro check form. During a phone interview on 5/15/2025 at 3:20 PM, the Pain Management NP said he saw Resident #1 the next day. He said Resident #1 was sitting up in his wheelchair, oriented and listening to his podcast. The Pain Management NP said he had spoken with ADON due to reviewing a progress note on Resident #1 indicating he was fatigued. He said he was going to adjust his medications during the visit, but the ADON had informed him of the medication error causing Resident #1's documented fatigue. Pain Management NP said Resident #1 was fully oriented, was not impaired and was in great condition when he saw him, and he had no concerns at the time of his visit. During an interview on 5/15/2025 at 3:29 PM, the Interim DON T said she was there are at the time of medication error. She said she was the Interim DON for the last 2-3 months. Interim DON T said LVN A had called her and told her she had got some medications for Resident #2 and had the new medications in the cup. She said she was heading to administer the medications and stopped to answer the call light and handed the cup of medications to the wrong resident. She said LVN A called and notified the NP and informed him about what had happened. Interim DON T said the NP had asked LVN A if Resident #1 had any changes and she said no. Interim DON T said the NP called her and discussed vital signs checks to be ordered every 30 minutes through the night and arouse resident. Interim DON T said the NP also wanted neuro every hour. She said the staff checked him for 24 hours and family was notified. She said the wife was notified and monitored Resident #1 for 3 days. The Interim DON said the NP came and checked Resident #1 out and he was doing good. Interim DON T said she checked on Resident #1 during the day. Interim DON T said she did not find out what was administered and did not put it on the incident report. She said the nurse said what the medications were, and she said they did check the allergies and the NP visited. Interim DON T said Resident #1 had been doing good. She said the only allergy Resident #1 had been to Motrin. Interim DON T said Resident #1 was not lethargic and the RP had checked on Resident #1 and talked to DON T about it. Interim DON T said she asked the ADON to complete the in-service and she spoke with LVN A about the 7 rights of medication administration. (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/15/2025 at 3:48 PM, the ADM said she was made aware of the medication error and what happened. She said she had spoken with the RP. The ADM said from what she knew, was the nurse had medications for another resident and Resident #1 received the medications instead. The ADM said LVN A handed Resident #1 the medications. The ADM said she was not aware of whose medication Resident #1 received and did not know if it was multiple medications. The ADM said in theory, it would be clinical and multiple departments assisting in the investigation. She said in her roll, she has checks and balances. She said she would involve HR to see if this had happened before. She said the investigation would be resident care and involve communication to NP or MD. The ADM said she did not know if each medication should have been listed on the investigation. She said the facility tries to identify and figure out during their investigation. The ADM said from her understanding, there was an investigation. She said she was made aware immediately what was happening. She said a medication error could negatively impact a resident that was not prescribed to him but would not elaborate. During an interview on 5/15/2025 at 4:30 PM, the ADM said she had spoken to the Corporate Nurse, and she was told the incident report was the investigation and there was not a separate investigation. 2. Record review of Resident #2's face sheet dated 5/16/2025 indicated he was readmitted to the facility on [DATE]. Resident #2's diagnosies included epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), cognitive communication (difficulties arising from impairments in cognitive function like attention, memory and executive functions, rather than issues with speech or language itself), diabetes mellitus (a group of diseases that result in too much sugar in the blood), mild intellectual disabilities (deficits in intellectual functions pertaining to abstract/theoretical thinking) and depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness and loss of interest or pleasure in activities previously enjoyed). Record review of a quarterly MDS assessment, dated 1/14/2025, indicated Resident #2 was usually understood and usually understood others. The MDS indicated Resident #2 had a BIMS score of 7 which indicated he was severely cognitively impaired, and he required substantial assistance with toileting, bathing, and dressing lower body. Record review of Resident # 2's care plan dated 10/29/2018 indicated Resident #2 uses anti-anxiety medications related to seizures diagnosis. Interventions included to administer anti-anxiety (Ativan, valium) medications as ordered by physician and monitor for side effects and effectiveness every shift. Interventions included to monitor, document, and report any adverse reactions to anti-anxiety therapy such as drowsiness, lack of energy clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double visit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's order summary report dated 5/16/2025 indicated Resident #2's evening medications were clobazam 20 mg 1 tablet twice daily (a medication used to treat seizures), diazepam 5 mg 1 tablet twice daily (a medication used to treat seizures), Docusate sodium 100 mg 1 capsule twice daily (a stool softener used to treat constipation), Keppra 1000 mg twice daily (a medication used to treat seizures), lamotrigine 200 mg 1 tablet three times daily (a medication used to treat seizures), Metformin 500 mg 1 tablet twice daily (a medication used to treat diabetes), Mirtazapine 15 mg 1 tablet at bedtime (a medication used to treat depression), Singular 10 mg 1 tablet at bedtime (a medication used to treat allergies), Topamax 200 mg 1 tablet twice daily (a medication used to treat seizures), and Trazadone 50 mg 1 tablet at bedtime (a medication to treat insomnia). Record review of Resident #2's MAR dated 5/1/2025-5/31/2025 indicated Resident #2 received his medications as ordered. The Administrator was notified on 5/15/2025 at 10:03 AM that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided the Immediate Jeopardy template on 5/15/2025 at 10:08 AM and a Plan of Removal was requested. The facility's Plan of Removal was accepted on 05/15/2025 at 2:37 PM and included: Plan of Removal F-760 Action: The Director of Nursing and/or Designee completed medication reconciliations to ensure that medications were given as ordered and documented on the MAR. The Director of Nursing and/or Designee reviewed the last 30 days of medication errors incidents to ensure that vital signs monitoring have been ordered and completed and documented include notification to physician of any allergies and adverse effects related to the medication error. Action/System Change: All licensed nurses and Certified Medication Aides were re-educated on 5/15/2025 by the Director of Nursing or designee on the following: Medication Administration Policy and Seven Rights of medication administration Medication errors to include writing orders as prescribed by Physician and Notification of adverse effects and resident allergies. Documentation and completion of vital signs as prescribed by the physician. Staff not in the facility on 5/15/2025 and/or on PTO/FMLA /Leave of Absence will have the re-education completed prior to the start of their next scheduled shift. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning 5/15/2025 and ongoing, newly hired licensed nurses will receive this training during orientation proper to providing care to the residents. The training will include the above-stated educational components. Medication error incidents will be reviewed during the morning clinical meeting to ensure that physicians were notified of any resident allergies related to medications received. Review will also ensure that monitoring of adverse effects to include vital signs were ordered, completed, and documented and physician was notified for abnormal findings. Completion and time was 5/15/2025 at 11:59 PM. Monitoring: Beginning 5/15/2025 and going forward, the Director of Nursing will monitor compliance with medication administration policy and the seven rights of medication administration. Beginning 5/15/2025 and going forward, the Director of Nursing/designee will monitor compliance each weekday morning on review of medication administration report and medication errors incidents to ensure medications are administered as ordered and physician notifications with orders written for monitoring of vital signs and adverse effects, carried out and documented in the record. The Administrator will attend the morning clinical meeting to ensure the Director of Nursing and/or designee reviews the incident report and medication administration report during the clinical meeting. On 5/15/2025, An Ad Hoc QAPI meeting was held with the Medical Director, Facility Administrator, Director of Nursing, and Regional Clinical Specialist to review the plan of removal. On 05/16/2025 at 12:49 PM the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Review of the Chart audits on medications indicated they were completed, and all resident's medication were reconciled with hospital discharges. No errors found. Review of the facility in-service dated 5/15/2025 The 10 Rights' Medication Administration indicated following: Right Medication- verifying that the medication administered is the correct one. Right Patient- Positively identify the patient. Right Dose- Checking the MAR/prescription to ensure the correct dosage was administered. Right [TRUNCATED]