STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455718	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pebble Creek Nursing Center	11608 Scott Simpson Dr El Paso, TX 79936

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 11 residents (Residents #16) reviewed for Neglect. The facility failed to immediately implement protective measures on 03/03/25 when the charge nurse reported to the DON concerns related to Resident #6 not receiving anticonvulsant medication according to the physician's order. The facility proceeded to allow the doses to be missed during the weekend of 3/08/25-03/09/25 without interventions/protections during that time. An Immediate Jeopardy (IJ) situation was identified on 05/18/25. While the IJ was removed on 05/20/25, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm , due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for further abuse and neglect. Findings include: Record Review of Resident #16's face sheet dated 05/15/25 revealed resident was a [AGE] year-old female with admission date 05/14/2024. Record Review of Resident #16's annual history and physical dated 05/16/25 revealed Resident #16 was non-verbal and was prescribed Levetiracetam 100mg/ml solution 7.5ml by mouth twice a day for seizures. Record Review of Resident #16's annual MDS dated [DATE] revealed there was no BIMS score due to resident's inability to answer questions. Resident #16 had the following diagnoses noted: Unspecified Dementia (A group of symptoms affecting memory, thinking, and social abilities), Dysphagia (difficulty swallowing), seizure disorder (abnormal electrical activity in your brain which causes changes in awareness and muscle control), Unspecified intellectual disabilities, Down Syndrome, and anxiety disorder. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of Resident #16's care plan with initiation date 05/15/25 revealed the resident had a Seizure disorder and interventions included for the facility staff to: administer seizure medication as ordered by the doctor, and seizure documentation should have included location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity. Review of Physician's Telephone Order dated 01/30/25 revealed: Levetiracetam (Keppra) 500 mg tablet give 1 tablet by mouth two times a day for Seizure Disorder. Discontinued Date: 01/30/25. Reason for Discontinue: Changed to liquid format due to medication instructions not to crush. Keppra Oral Solution 100 mg/ml give 5 ml by mouth two times for seizures. Review of Physician's Telephone Order dated 03/03/25 revealed Order Summary: Keppra Oral Solution 100 mg/ml give 7.5 ml by mouth two times for seizures. Review of Lab report dated 02/24/25 revealed Levetiracetam (Keppra) level was Low 2.50 (Reference Range 6.00 - 46.00 ug/ml) Review of Resident #16's electronic medication administration record revealed Levetiracetam oral solution 100mg/ml, 7.5ml by mouth two times a day related to seizures was marked as administered by Medication Aide A on Saturday 03/08/25 at 08:00AM and 08:00 PM, and Sunday 03/09/25 at 08:00 AM. Review of electronic medication administration records revealed Medication Aide B marked Levetiracetam (oral solution 100mg/ml, 7.5ml by mouth two times a day related to seizures) as administered on Sunday 03/09/25 at 08:00 PM. Review of Event Nurses Note dated 05/15/25 written by the DON revealed Resident #16 medication was not administered as prescribed resulting in a seizure, no injuries. Event Nurses Note revealed physician was notified 03/10/25 at 08:41 AM. Review of the undated Employee Time Entry Report with no date revealed Medication Aide A worked Saturday 03/08/2025 from 6:38 AM to 10:06 PM, and Sunday 03/08/25 from 6:42 AM to 2:34 PM. Review of Employee Time Entry Report dated 05/20/25 revealed Medication Aide B worked Sunday 03/09/25 from 2:08 PM to 10:04 PM. Review of facility Progress Notes dated 05/19/25 revealed Nurse Practitioner reviewed Levetiracetam labs on 03/03/25 and results were low at 2.50, new orders added to increase Levetiracetam to 7.5ml twice a day. Review of nursing progress notes dated 03/10/25 at 09:00 AM revealed LVN C documented a CNA notified him of Resident #16 having spasms while eating breakfast. LVN C documented he monitored Resident #16 and she started having seizure like movements. LVN C documented Resident #16 had abnormal breathing, oxygen decreased, placed on supplemental oxygen 2 L (liters) NC (Nasal Cannula, a medical device used to deliver supplemental oxygen directly into the nostrils, helping individuals with respiratory issues breathe more easily) . Seizure lasted 1 minute 38 seconds. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Medication Error Form dated 03/10/25 completed by the DON revealed, Date of Occurrence: 03/10/25 at 8:00 AM, Type of Incident: Medication not administered as ordered. Description of Incident: Medication not given over the weekend. Physician Order: Keppra level. No medication changes. Interview on 05/15/25 at 03:20 PM with LVN C revealed that he had notified the physician on Monday 03/10/25 to report that Resident #16 had not been administered 4 doses of the Keppra, and the physician had come to assess the resident on that day at 9:20 a.m. Interview on 05/15/25 at 04:04 PM with the DON revealed LVN C had reported to her on 03/03/25 that he suspected the weekend Medication Aide A was not administering the Keppra to Resident #16 as ordered because the Keppra level was low. The DON stated that she told LVN C on that day that she needed to have concrete evidence to show that the resident was not getting Keppra as ordered. So, she instructed LVN C on 03/07/25 to take a picture of the Keppra's liquid medication bottle after the night dose was administered, and that they would check the level of medication in the on Monday morning 03/10/25, to determine if the Keppra had been administered on the weekend by Medication Aide A according to physician's orders. The DON stated that she had not reported this allegation to the Administrator and had not immediately initiated an investigation to determine if the Resident #16 was being administered the Keppra as ordered and had not initiated any interventions until 03/12/25 when she initiated the anticonvulsive medication audits to determine if medications were being administered according to physician's orders. In a telephone interview on 05/15/25 at 5:23 PM with the Nurse Practitioner, she stated the facility investigated and confirmed Resident #16's seizure medication was not administered over the weekend of 03/08/25-03/09/25, as ordered. She stated Keppra labs were completed 03/11/25, the day after the resident's seizure, and the result values were within normal limits. She stated Resident #16 missing the 4 doses could be a possible reason the resident had a seizure. The Nurse Practitioner stated the Keppra Medication was not to be stopped abruptly and would need to be tapered off to prevent adverse reactions such as seizures. In a telephone interview on 05/15/25 at 05:48 PM with the Primary Physician, she stated Resident #16 was at increased risk for seizures from missing 4 Levetiracetam medication doses. She stated she was unable to call post Keppra lab values, but a patient could still experience seizures even with normal Keppra lab values. Interview on 05/16/25 at 03:52PM with the Administrator revealed he was the Abuse Coordinator. He stated he was notified by the DON reported the allegation of medication not being administered as ordered and it was an allegation of neglect. He stated he did not report it to HHSC, and he was not able to provide a reason why he did not call. Second interview on 05/18/25 with LVN C assigned to Resident #16 reported that on 03/10/25, Resident #16 was having shaking of her extremities, became unresponsive for a few seconds, eyes rolled back, muscle jerking, and oxygen dropped to 87%. She stated this last for 1 min and 38 seconds. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 05/18/25 at 1:45 PM with Medication Aide B, he stated he recalled working Sunday afternoon shift on 03/09/25. He stated he did not administer Levetiracetam since it was liquid form which was kept in a different drawer of the medication cart. He stated he did not pull the bottle out of the drawer. He stated he recalled signing the MAR Levetiracetam as administered though he did not. He stated he was trained to pull out medications, compare labels to MAR, including name of resident, name of medication, dosage and frequency. He stated he did not pull-out medication of the drawer and did not administer it that day. He stated he forgot to administer it since it was in a different drawer. In a telephone interview on 05/18/25 at 02:30 PM with Medication Aide A, she stated she recalled not administering the Keppra medication the weekend of 03/08/25 for the 08:00 AM and 08:00 PM doses, and 03/09/25 for the 08:00 AM because she was helping answer a call light. She stated she intended to go back to administer the Keppra medication, but she forgot after helping answer the call light. She stated it was an honest mistake. She stated she had been previously counseled for not administering saline eye drops in 11/2024 though she documented she had on the electronic medication administration record. She stated she was trained to administer medications as ordered. Review of the facility's policy titled Abuse/Neglect revealed the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse and situations that may constitute abuse or neglect to any facility. Definitions: Neglect: Is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Prevention.: The facility will provide the residents, families, and staff an environment free from abuse and neglect. All reports of abuse or suspicion of abuse/neglect will be investigated as per facility protocol. The facility will be responsible to identify, correct and intervene in situations of possible abuse/neglect. Protection.: The facility will take necessary measures to protect residents and employees from harm during and following an abuse, neglect, exploitation, mistreatment of residents, or misappropriation of a resident's property. This was determined to be an Immediate Jeopardy (IJ) on 05/18/2025 at 5:11 p.m. The Administrator was notified and requested a POR within one hour. The Administrator was provided with the IJ template on 05/18/2025 at 5:24 p.m. The following Plan of Removal submitted by the facility was accepted on 5/19/2025 at 5:00 p.m.: Interventions: -The alleged perpetrator Medication Aide A was terminated on 03/12/2025 . -Medication Aide B was counselled on 03/10/25 for not administering Keppra as ordered 03/09/25 at 8:00 PM. -On 3/24/25, 03/12/25, 03/17/25, 03/24/25 medication pass observation/evaluation was completed with Medication Aide B by the DON to verify that he was administering medications according to doctors' orders and no concerns were identified during the med pass observation . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The administrator reported on 05/15/25 to HHS an allegation of neglect related to failure to administer anticonvulsant medications as ordered. -Out of cycle QAPI including this plan was presented to the Medical Director by the facility administrator. The medical director did not request changes to the plan. Completed 5/16/2025 -On 05/16/25, the ADONS conducted a random count of all anticonvulsant medications to ensure that medications were being administered according to doctors' orders. The ADONS continue to conduct random checks of the anticonvulsant medications to ensure that medications are administered according to doctor's orders. The Administrator and Regional Compliance Nurse will randomly check that the ADONS are completing the random checks to ensure that medications are administered according to doctors' orders. -The DON completed a medication error report on 03/10/25 for the 4 Keppra Doses that were not administered on 03/08/25 and 03/09/25 by the medication aids. The medication error report was reviewed and signed by the attending physician on 03/12/25. -Audit of Anticonvulsant therapeutic labs conducted between 04/17/25 and 04/21/25 by ADON. No concerns were identified. The ADONs will continue to conduct random anticonvulsant therapeutic audits to ensure that labs have been completed according to doctors' orders and any abnormal levels are immediately reported to the physician. -Random medication pass observations were completed on 05/02/25, 05/15/25 and 05/17/25 by ADONs . No concerns were identified. -Regional compliance nurse will randomly check on a weekly basis that the ADONs/DON are conducting random medication pass observations to ensure that medications are administered according to doctors order. In-services: -All Licensed Nurses and Medication Aides by the DON, ADON and Regional Compliance Nurse. o Medication administration Policy. Completed on 3/12/2025 and 5/16/2025 o Following Physicians' orders. Completed on 5/16/2025 o Following the notification of physician when resident has a change in status: 5/16/2025 o Anticonvulsant medication count. Completed on 5/16/2025 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Ensure that therapeutic levels are drawn as ordered. Completed on 5/16/2025 -One to one in service for Administrator and DON on following policies and procedures to prevent abuse and neglect: Time frame of 2-24hrs: Completed by ADO on 5/16/2025 at 7:44pm -New Direct Care staff are to be in-serviced during the facility orientation. No staff will be allowed to take a shift until in-service education is completed. Monitoring of the facility's plan of removal included the following: Record review of Medication Aide A's discharge documentation for date of infractions noted 03/08/25-03/09/25, and Medication Aide A failed to administer Keppra to prevent seizures and falsely documented it on 03/08 and 03/09, 2nd offense termination requested. Document signed by the Administrator and the DON, dated 03/10/25. Record review of Medication Aide B's counseling document dated 03/10/25 for failed to adhere to corporate code of conduct and job duties. It noted Medication Aide B failed to administer to administer medication and falsified documentation stated that medication was given on days 03/08/25 and 03/09/25. Record review of medication pass observations completed by the DON while observing Medication Aide B 3/24/25, 03/12/25, 03/17/25, 03/24/25, to verify that he was administering medications according to doctors' orders and no concerns were identified during the med pass observation . Record review of anticonvulsant medication's were accounted of by ADONs dated 05/16/25. No issues noted. Record review of medication pass of various staff by the ADON's dated 05/02/25, 05/15/25, and 05/17/25. During an interview on 05/20/2025 at 9:57 am with LVN C revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation (ANE) immediately to facility administrator as he was Abuse Coordinator. He stated that the abuse coordinator contact information was posted outside of the human resourses office and at the front desk when entering the building. LVN C stated that if the Abuse Coordinator was not available, he would notify DON immediately. He stated that not administering medications to residents as per doctors' orders was considered neglect and would report it to the Abuse Coordinator and DON immediately. He stated that nurses could confirm if medications were being administered by med aides by looking at the count sheet and by reviewing the MAR. During an interview on 05/20/25 at 10:00 AM with Resident # 45, he stated he liked living at the facility and said staff treated him with respect and dignity. Resident # 45 said he always got his medications supervised every day and had not had issues with running out of medications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview on 05/20/25 at 10:00 AM with LVN AA revealed she was aware of the Abuse coordinator who was the Administrator. She stated she was trained to report allegations of ANE immediately to the Abuse Coordinator. She stated there was an orange sign with the Abuse Coordinator's contact information that was in the front office and in front of Human Resources. LVN AA stated if the Abuse Coordinator was not available, she would notify the DON of allegations immediately. She stated there was a new policy for only nurses to administer anticonvulsants as ordered. She stated not administering medications as ordered would be considered neglect and she would report that concern or allegation to the Abuse Coordinator immediately. An interview on 05/20/2025 at 10:06 AM with Med Aide R revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation immediately to facility administrator as he was Abuse Coordinator. She stated that his contact information was posted outside of the human resourses office and at the front desk when entering the building. Med Aide R stated that if the Abuse Coordinator was not available, she would notify DON immediately. She stated that not administering medications to residents as per doctors' orders was considered neglect and would report it to the Abuse Coordinator and DON. During an Interview on 05/20/2025 at 10:07 AM with CNA O revealed the facility provided training on 5/19/25 on how to report Abuse Neglect and Exploitation. She stated she would contact the abuse prohibition coordinator immediately if she suspected ANE and knew to find his phone number and contact information in the lobby. CNA O said in case that she was not able to contact the abuse prohibition coordinator, she would report it to the DON, ADON or call the state number and report it. She said the nurses were responsible for administering anticonvulsants. During an interview on 05/20/2025 at 10:11AM with RN S revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation immediately to facility administrator as he was Abuse Coordinator. He stated that the abuse coordinator contact information was posted outside of the human resourses office and at the front desk when entering the building. LVN S stated that if the Abuse Coordinator was not available, he would notify DON immediately. He stated that not administering medications to residents as per doctors' orders was considered neglect and he would report it to the Abuse Coordinator and DON. He stated that nurses could confirm if medications were being administered by med aides by looking at the count sheet and by reviewing the MAR. He stated that if medaids' have questions they knew to come to him and ask for clarification. During an Interview on 05/20/2025 at 10:16 AM with CNA J revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation immediately to facility administrator as he was Abuse Coordinator. She stated that his contact information was posted outside of the human resourses office and at the front desk when entering the building. CNA J stated that if the Abuse Coordinator was not available, she would notify DON immediately. During an interview on 05/20/25 at 10:24 AM with Med Aide G revealed she was trained on 5/19/25 on how to immediately report ANE to the abuse coordinator, DON, ADON or the state. She said the contact information was available for all staff and residents in the hallways of the facility as well as in the lobby. Med Aide G stated only nurses were able to supervise anticonvulsant medications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/20/25 at 10:27 AM with ADON K revealed the facility provided training on reporting allegations of Abuse, Neglect, and Exploitation immediately to the Abuse Coordinator, who was the Administrator. She stated if the Abuse Coordinator was not at the facility, she would be able to obtain his phone number located outside the Human Resources office or by the front desk. She stated if he were not available, the next person to notify was the DON immediately. ADON K stated nurses were responsible for administering medications as ordered. She stated nurses could confirm medications were administered as ordered by confirming with the MAR and the count sheet. She stated medications that were not administered as ordered was neglect and it was to be reported to the physician, DON, and the Abuse Coordinator. During an interview on 05/20/25 at 10:28 AM with LVN N revealed she had been in-serviced on 5/19/25 about ANE and how to report it. She stated she had to immediately report it to the abuse coordinator and if he was not in the facility she had to immediately report to the DON, ADON or call the state. She said only nurses were able to supervise anticonvulsant medications. During an interview on 5/20/25 at 10:31 AM with Med Aide T revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation immediately to facility administrator as he was Abuse Coordinator. She stated that his contact information was posted outside of the human resourses office and at the front desk when entering the building. Med Aide T stated that if the Abuse Coordinator was not available, she would notify DON immediately. She stated that not administering medications to residents as per doctors' orders was considered neglect and would report it to the Abuse Coordinator and DON. During an interview on 05/20/2025 at 10:38 AM with CNA E revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation immediately to facility administrator as he was Abuse Coordinator. He stated that his contact information was posted outside of the human recourses office and at the front desk when entering the building. CNA E stated that if the Abuse Coordinator was not available, He would notify DON immediately. During an interview on 05/20/25 at 10:45 AM with the DON revealed the Regional Compliance Nurse and the ADON's would monitor medication administration weekly to ensure it was administered as ordered. She stated the ADON's would be doing random medication passes with Medication Aides. She stated she received in-service training in reporting Abuse, Neglect, and Exploitation within a 2-24-hour timeframe to the Abuse Coordinator. She stated she was aware that the Abuse Coordinator's contact information was located by the Human Resources office and the front desk. She stated if he was not available, she would be responsible for reporting it to HHSC and initiate an investigation. During an interview on 05/20/25 at 10:51 AM with LVN I revealed she had been trained on 05/19/25 and 05/20/25 on how to report ANE. She stated she had to report it immediately to the abuse prohibition coordinator and if he was not available, she would immediately report it to the DON and ADON. She said the contact information for reporting could be found in the hallways of the facility and in the lobby or front entrance. She stated only nurses were able to administer anticonvulsant medications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/20/25 at 10:56 AM with Med Aide U revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation immediately to facility administrator as he was Abuse Coordinator. She stated that his contact information was posted outside of the human resourses office and at the front desk when entering the building. Med Aide T stated that if the Abuse Coordinator was not available, she would notify DON immediately. She stated that not administering medications to residents as per doctors' orders was considered neglect and would report it to the Abuse Coordinator and DON. During an interview on 05/20/25 at 10:58 AM with CNA Q revealed she had been in-serviced on how to immediately report ANE either to the state number or to the abuse prohibition coordinator and to the DON and ADON if she was not able to communicate with the administrator. CNA Q said she could find the contact information for the state and the abuse coordinator in the hallways from the facility and in the lobby at the front entrance. CNA Q said only nurses were able to supervise anticonvulsant medications and that she had been in-serviced on the administration of that medication in the last training provided on 5/19/25. During an interview on 05/20/25 at 11:04 AM with CNA V revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation immediately to facility administrator as he was Abuse Coordinator. She stated that his contact information was posted outside of the human resourses office and at the front desk when entering the building. CNA V stated that if the Abuse Coordinator was not available, she would notify DON immediately. During a telephone interview at 05/20/25 at 11:21 AM with LVN BB revealed he was trained for reporting allegations of Abuse, Neglect, and Exploitation immediately to the Abuse Coordinator. He stated the Abuse Coordinator was the Administrator and his contact information was located outside the Human Resources office and by the front desk. He stated that if the Abuse Coordinator was not available, he would report it to the DON immediately. He stated if staff were to intentionally not administer medication as ordered but documented on the electronic medication administration record as administered, that was Neglect and to be reported to the Abuse Coordinator immediately. Record review of the facility's document titled In-Service Training Attendance Roster, dated 05/16/25 In-Service Training Topic: Abuse, Neglect, and Exploitation. Record review of the facility's document titled In-Service Training Attendance Roster, dated 5/16/2025 In-Service Training Topic: Medication Administration Policy. Record review of facility's Nursing Policy and Procedure Manual, with no date, titled Abuse/Neglect, read in part: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Definitions: Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . (continued on next page)

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	455718	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pebble Creek Nursing Center	11608 Scott Simpson Dr El Paso, TX 79936

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Administrator was informed that the IJ was removed on 05/20/2025 at 12:30 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment the facility had evidence that all alleged violations were thoroughly investigated and prevent further abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 1 of 11 residents (Residents #16) reviewed for abuse/neglect. - The facility failed to investigate, prevent, correct, and report alleged violations of neglect for Resident #16 when reported by LVN C on 03/03/25. An Immediate Jeopardy (IJ) was identified on 05/18/25. While the IJ was removed on 5/20/25, the facility remained out of compliance at a severity level of actual harm not IJ with a scope of pattern because the facility had not had time to monitor their plan of removal for effectiveness. These failures could place residents at risk for further abuse, and neglect. Findings include: Record Review of Resident #16's face sheet dated 05/15/25 revealed resident was a [AGE] year-old female with admission date 05/14/2024. Record Review of Resident #16's annual history and physical dated 05/16/25 revealed Resident #16 was non-verbal and was prescribed Levetiracetam 100mg/ml solution 7.5ml by mouth twice a day for seizures. Record Review of Resident #16's annual MDS dated [DATE] revealed there was no BIMS score due to resident's inability to answer questions. Resident #16 had the following diagnoses noted: Unspecified Dementia (A group of symptoms affecting memory, thinking, and social abilities), Dysphagia (difficulty swallowing), seizure disorder (abnormal electrical activity in your brain which causes changes in awareness and muscle control), Unspecified intellectual disabilities, Down Syndrome, and anxiety disorder. Record Review of Resident #16's care plan with initiation date 05/15/25 revealed the resident had a Seizure disorder and interventions included for the facility staff to: administer seizure medication as ordered by the doctor, and seizure documentation should have included location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity. Review of Physician's Telephone Order dated 01/30/25 revealed Order Summary: Levetiracetam (Keppra) 500 mg tablet give 1 tablet by mouth two times a day for Seizure Disorder. Discontinued Date: 01/30/25. Reason for Discontinue: Changed to liquid format due to medication instructions not to crush. Keppra Oral Solution 100 mg/ml give 5 ml by mouth two times for seizures. Review of Lab report dated 02/24/25 revealed Levetiracetam (Keppra) level was Low 2.50 (Reference Range 6.00 - 46.00 ug/ml) (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Physician's Telephone Order dated 03/03/25 revealed Order Summary: Keppra Oral Solution 100 mg/ml give 7.5 ml by mouth two times for seizures. Record review of anticonvulsant monitoring forms dated 03/12/25, 03/14/25, 03/17/25, and 03/24/25 for 7 of 7 residents on anticonvulsants. Interview on 05/15/25 at 04:04 PM with the DON revealed LVN C, assigned to Resident #16, had reported to her on 03/03/25 that he suspected the weekend Medication Aide A was not administering the Keppra to Resident #16 as ordered because the Keppra level was low. The DON stated that she told LVN C on that day that she needed to have concrete evidence to show that the resident was not getting Keppra as ordered. So, she instructed LVN C on 03/07/25 to take a picture of the Keppra's medication bottle after the night dose was administered, and that they would check the level of medication in the on Monday morning 03/10/25, to determine if the Keppra had been administered on the weekend by Medication Aide A according to physician's orders. The DON stated that she had not reported this allegation to the Administrator and had not immediately initiated an investigation to determine if the Resident #16 was being administered the Keppra as ordered and had initiated any interventions until 03/12/25 when she initiated the anticonvulsive medication audits to determine if medications where being administered according to physician's orders. In an interview on 05/16/25 at 11:32 AM with LVN C, he stated he suspected Medication Aide A was not administering Resident #16's Levetiracetam medication as ordered. He stated he notified the DON that day of his suspicion on Monday 03/03/25. Interview on 05/16/25 at 03:52PM with the Administrator revealed he was the Abuse Coordinator, and he was to report and initiate an investigation into the allegation of neglect. He stated the DON informed him of the suspicion that the Medication Aide A was not administering Resident #16's medication as ordered before the weekend of Saturday 03/08/25 and Sunday 03/09/25, but could not recall the exact date he was informed by the DON. He said that he was aware that a picture was going to be taken , and the DON and Charge were going to check the level of medication on Monday 03/10/25. He stated that he did not recall if the DON had mentioned to him what action was going to protect the residents until they had evidence to prove that the medication was not being administered as ordered. During a telephone interview on 05/18/25 at 4:44 PM with LVN C, it was revealed he observed Resident #16 during her seizure on 03/10/25. He stated he observed resident #16 shaking her extremities, resident #16 had her eyes rolled back, and that was observed for 1 minute and 38 seconds. LVN C stated Resident #16's arms were observed jerking but was not rigid. LVN C stated Resident #16's oxygen was monitored and dropped to a level 87% on room air until staff administered oxygen supplementation via nasal cannula. He stated he observed Resident #16 with a blank stare and observed unconsciousness . During an Interview on 05/20/2025 at 10:07 AM with CNA O revealed the facility provided training on 5/19/25 on how to report Abuse Neglect and Exploitation. She stated she would contact the abuse prohibition coordinator immediately if she suspected ANE and knew to find his phone number and contact information in the lobby. CNA O said in case that she was not able to contact the abuse prohibition coordinator, she would report it to the DON, ADON or call the state number and report. She said the nurses were responsible for administering anticonvulsants. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This was determined to be an Immediate Jeopardy (IJ) on 05/18/2025 at 5:11 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 05/18/2025 at 5:24 p.m. The following Plan of Removal submitted by the facility was accepted on 5/19/2025 at 5:00 p.m.: Interventions: -The alleged perpetrator Medication Aide A was terminated on 5/12/2025. -Medication aide B was counseled on 03/10/25 for not administering Keppra as ordered 03/09/25 at 8:00 PM. -On 3/24/25, 03/12/25, 03/17/25, 03/24/25 medication pass observation/evaluation was completed with Med aide #2 by the DON to verify that he was administering medications according to doctors' orders and no concerns were identified during the med pass observation. -The administrator reported on 05/15/25 to HHS an allegation of neglect related to failure to administer anticonvulsant medications as ordered. -Out of cycle QAPI, this plan was presented to the Medical Director by the facility administrator. The medical director did not request changes to the plan. Completed 5/16/2025 -On 05/16/25, the ADONS conducted a random count of all anticonvulsant medications to ensure that medications were being administered according to doctors' orders. The ADONS continue to conduct random checks of the anticonvulsant medications to ensure that medications are administered according to doctor's orders. The Administrator and Regional Compliance Nurse will randomly check that the ADONS are completing the random checks to ensure that medications are administered according to doctors' orders. -The DON completed a medication error report on 03/10/25 for the 4 Keppra Doses that were not administered on 03/08/25 and 03/09/25 by the medication aids. The medication error report was reviewed and signed by the attending physician on 03/12/25. -Random medication pass observations were completed on 05/02/25, 05/15/25 and 05/17/25 by ADONs. No concerns were identified. -The facility administrator and DON will immediately report all allegations of abuse and neglect to HHSC, Regional Compliance Nurse and Area Director of Operations to ensure that all abuse and neglect allegations are immediately investigated to prevent further abuse and neglect. -Regional Compliance Nurse and Area Director of Operations will randomly check during weekly visits that all abuse and neglect allegations are immediately reported to HHS and that an internal investigation was immediately initiated to prevent further abuse and neglect. In-services: 1. All Licensed Nurses and Medication Aides by the DON, ADON and Regional Compliance Nurse. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Medication administration Policy. Completed on 3/12/2025 &5/16/2025 o Following Physicians orders. Completed on 5/16/2025 o Following the notification of physician when resident has a change in status: 5/16/2025 o Anticonvulsant medication count. Completed on 5/16/2025 o Ensure that therapeutic levels are drawn as ordered. Completed on 5/16/2025 2. One to one in service for Administrator and DON on following policies and procedures to prevent abuse and neglect: Time frame of 2-24hrs: Completed by ADO on 5/16/2025 @ 7:44pm which included training on all allegations of abuse and neglect will be immediately reported to the administrator and will thoroughly investigate the allegations to prevent further abuse and neglect while the investigation is in progress and will take appropriate action as a result of the investigation findings. 3. New Direct Care staff are to be in-serviced during the facility orientation. No staff will be allowed to take a shift until in-service education is completed. Monitoring of the facility's plan of removal included the following: During an interview on 05/20/25 at 10:00 AM with LVN AA revealed she was aware of the Abuse coordinator who was the Administrator. She stated she was trained to report allegations of ANE immediately to the Abuse Coordinator. She stated there was an orange sign with the Abuse Coordinator's contact information that was in the front office and in front of Human Resources. LVN AA stated if the Abuse Coordinator was not available, she would notify the DON of allegations immediately. She stated there was a new policy for only nurses to administer anticonvulsants as ordered. She stated not administering medications as ordered would be considered neglect and she would report that concern or allegation to the Abuse Coordinator immediately. During an interview on 05/20/25 at 10:24 AM with Med Aide G revealed she was trained on 5/19/25 on how to immediately report ANE to the abuse coordinator, DON, ADON or the state. She said the contact information was available for all staff and residents in the hallways of the facility as well as in the lobby. Med Aide G stated only nurses were able to supervise anticonvulsant medications. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/20/25 at 10:27 AM with ADON K revealed the facility provided training on reporting allegations of Abuse, Neglect, and Exploitation immediately to the Abuse Coordinator, who was the Administrator. She stated if the Abuse Coordinator was not at the facility, she would be able to obtain his phone number located outside the Human Resources office or by the front desk. She stated if he were not available, the next person to notify was the DON immediately. ADON K stated nurses were responsible for administering medications as ordered. She stated nurses could confirm medications were administered as ordered by confirming with the MAR and the count sheet. She stated medications that were not administered as ordered was neglect and it was to be reported to the physician, DON, and the Abuse Coordinator. During an interview on 05/20/25 at 10:28 AM with LVN N revealed she had been in-serviced on 5/19/25 about ANE and how to report it. She stated she had to immediately report it to the abuse coordinator and if he was not in the facility she had to immediately report to the DON, ADON or call the state. She said only nurses were able to supervise anticonvulsant medications. During an interview on 05/20/25 at 10:45 AM with the DON stated the Regional Compliance Nurse and the ADON's would monitor medication administration weekly to ensure it was administered as ordered. ADON's will be doing random medication passes with Medication Aides. She stated she received in-service training in reporting Abuse, Neglect, and Exploitation within a 2-24-hour timeframe to the Abuse Coordinator. She stated she was aware that the Abuse Coordinator's contact information was located by the Human Resources office and the front desk. She stated if he was not available, she would be responsible for reporting it to HHSC and initiate an investigation. During an interview on 05/20/25 at 10:47 AM with CNA P revealed she had been trained in how to report ANE on 5/19/25. She stated she would report it to the abuse prohibition coordinator or the administrator. CNA P said she could find his contact information in the lobby of the facility and in the room where the staff clocked in. She said if she was not able to communicate with the administrator, she would report to the DON or ADON and also call the state. CNA P said suspicions of ANE had to be reported immediately. She stated that regarding anticonvulsant medications, only the nurses were able to supervise them. During an interview on 05/20/25 at 10:51 AM with LVN I revealed she had been trained on 5/19/25 and in 5/20/25 on how to report ANE. She stated she had to report it immediately to the abuse prohibition coordinator and if he was not available, she would immediately report it to the DON and ADON. She said the contact information for reporting could be found in the hallways of the facility and in the lobby or front entrance. She stated only nurses were able to administer anticonvulsant medications. During an interview on 05/20/25 at 10:58 AM with CNA Q revealed she had been in-serviced on how to immediately report ANE either to the state number or to the abuse prohibition coordinator and to the DON and ADON if she was not able to communicate with the administrator. CNA Q said she could find the contact information for the state and the abuse coordinator in the hallways from the facility and in the lobby at the front entrance. CNA Q said only nurses were able to supervise anticonvulsant medications and that she had been in-serviced on the administration of that medication in the last training provided on 5/19/25. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview at 05/20/25 at 11:21 AM with LVN BB revealed he was trained for reporting allegations of Abuse, Neglect, and Exploitation immediately to the Abuse Coordinator. He stated the Abuse Coordinator was the Administrator and his contact information was located outside the Human Resources office and by the front desk. He stated that if the Abuse Coordinator was not available, he would report it to the DON immediately. He stated if staff were to intentionally not administer medication as ordered but documented on the electronic medication administration record as administered, that was Neglect and to be reported to the Abuse Coordinator immediately Record Review of Event Nurses' Notes dated 05/15/25, written by the DON noted Resident #16 was not administered medication as prescribed and had a seizure as a results with no injuries on 03/10/25. Record review of the facility's document titled In-Service Training Attendance Roster, dated 05/16/25 In-Service Training Topic: Abuse, Neglect, and Exploitation. Record review of the facility's document titled In-Service Training Attendance Roster, dated 5/16/2025 In-Service Training Topic: Medication Administration Policy. Record review of Nursing Policy and Procedure Manual, with no date, titled Abuse/Neglect, read in part: C. Prevention: All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy. The Administrator was informed that the IJ was removed on 05/20/2025 at 12:30 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Deficiency Text Not Available

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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 - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free of significant medication errors for 1 (Resident # 16) of 6 residents reviewed for pharmacy services. The facility failed to administer Resident #16's Levetiracetam 100 mg/ml 7.5 ml by mouth two times on 03/08/25 at 8:00 a.m. and 8:00 p.m. and two times on 03/09/25 at 8:00 a.m. and at 8:00 p.m. according to physician orders. An Immediate Jeopardy (IJ) was identified on 05/18/25. While the IJ was removed on 5/20/25, the facility remained out of compliance at a severity level of actual harm not IJ with a scope of pattern because the facility had not had time to monitor their plan of removal for effectiveness. This failure placed residents on anticonvulsant medications at risk for harm, or neglect. The findings included: Record Review of Resident #16's face sheet dated 05/15/25 revealed resident was a [AGE] year-old female with admission date 05/14/2024. Record Review of Resident #16's annual history and physical dated 05/16/25 revealed Resident #16 was non-verbal and was prescribed Levetiracetam 100mg/ml solution 7.5ml by mouth twice a day for seizures. Record Review of Resident #16's annual MDS dated [DATE] revealed there was no BIMS score due to resident's inability to answer questions. Resident #16 had the following diagnoses noted: Unspecified Dementia (A group of symptoms affecting memory, thinking, and social abilities), Dysphagia (difficulty swallowing), seizure disorder (abnormal electrical activity in your brain which causes changes in awareness and muscle control), Unspecified intellectual disabilities, Down Syndrome, and anxiety disorder. Record Review of Resident #16's care plan with initiation date 05/15/25 revealed the resident had a Seizure disorder and interventions included for the facility staff to: administer seizure medication as ordered by the doctor, and seizure documentation should have included location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity. Review of Physician's Telephone Order dated 01/30/25 revealed Order Summary: Levetiracetam (Keppra) 500 mg tablet give 1 tablet by mouth two times a day for Seizure Disorder. Discontinue Date: 01/30/25. Reason for Discontinue: Changed to liquid format due to medication instructions not to crush. Keppra Oral Solution 100 mg/ml give 5 ml by mouth two times for seizures. Review of Lab report dated 02/24/25 revealed Levetiracetam (Keppra) level was Low 2.50 (Reference Range 6.00 - 46.00 ug/ml) Review of Physician's Telephone Order dated 03/03/25 revealed Order Summary: Keppra Oral Solution 100 mg/ml give 7.5 ml by mouth two times for seizures. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #16's electronic medication administration record revealed Levetiracetam oral solution 100mg/ml, 7.5ml by mouth two times a day related to seizures was marked as administered by Medication Aide A on Saturday 03/08/25 at 08:00AM and 08:00 PM, and Sunday 03/09/25 at 08:00 AM. Review of electronic medication administration records revealed Medication Aide B marked Levetiracetam oral solution 100mg/ml, 7.5ml by mouth two times a day related to seizures as administered on Sunday 03/09/25 at 08:00 PM. Review of Event Nurses Note dated 05/15/25 written by the DON revealed resident #16 medication was not administered as prescribed resulting in a seizure, no injuries. Event Nurses Note revealed physician was notified 03/10/25 at 08:41 AM. Review of Employee Time Entry Report with no date revealed Medication Aide A worked Saturday 03/08/2025 from 6:38 AM to 10:06 PM, and Sunday 03/08/25 from 6:42 AM to 2:34 PM. Review of Employee Time Entry Report dated 05/20/25 revealed Medication Aide B worked Sunday 03/09/25 from 2:08 PM to 10:04 PM. Record review of anticonvulsant monitoring forms dated 03/12/25, 03/14/25, 03/17/25, and 03/24/25 for 7 of 7 residents on anticonvulsants. Interview on 05/15/25 at 04:04PM with the DON revealed, on 03/03/25, LVN C reported he suspected Medication Aide A was not administering Levetiracetam, anticonvulsant medication that generally treats seizures, as ordered for Resident #16. She stated she reconciled medications that week of Monday 03/03/25 to Friday 03/07/25 and found no discrepancies. She stated she instructed LVN C to take a picture of Resident #16's levetiracetam medication bottle friday 03/07/25 to compare the amount on Monday 03/10/25. She stated the amount of the medication was unchanged from both days. She stated two medication aides, Medication Aide A and Medication Aide B, did not administer the medication as ordered. In an interview on 05/15/25 at 6:02 PM with LVN C, he stated he was instructed by the DON to take pictures of Resident #16's medication bottle Friday 03/07/25 and compare the amount on Monday 03/10/25. He stated there were no other instructions instructed by the DON at that time. Interview on 05/16/25 at 03:52PM with Administrator revealed he was the Abuse Coordinator, and he was to report and initiate an investigation into the allegation of neglect. He stated the DON informed him of the suspicion that the Medication Aide A was not administering Resident #16's medication as ordered before the weekend of Saturday 03/08/25 and Sunday 03/09/25 but could not recall the exact date he was informed by the DON. He said that he was aware that a picture was going to be taken, and the DON and Charge were going to check the level of medication on Monday 03/10/25. He stated that he did not recall if the DON had mentioned to him what action was going to protect the residents until they had evidence to prove that the medication was not being administered as ordered. (continued on next page)

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	455718	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pebble Creek Nursing Center	11608 Scott Simpson Dr El Paso, TX 79936

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 05/18/25 at 1:45 PM with Medication Aide B, he stated he recalled working Sunday afternoon shift on 03/09/25. He stated he did not administer Levetiracetam since it was liquid form which was kept in a different drawer of the medication cart. He stated he did not pull the bottle out of the drawer. He stated he recalled signing the MAR Levetiracetam as administered though he did not. He stated he was trained to pull out medications, compare labels to MAR, including name of resident, name of medication, dosage and frequency. He stated he did not pull-out medication of the drawer and did not administer it that day. In a telephone interview on 05/18/25 at 02:30 PM with Medication Aide A, she stated she recalled not administering the Keppra medication the weekend of 03/08/25 for the 08:00 AM and 08:00 PM doses, and 03/09/25 for the 08:00 AM because she was helping answer a call light. She stated she intended to go back to administer the Keppra medication, but she forgot after helping answer the call light. She stated it was an honest mistake. She stated she had been previously counseled for not administering saline eye drops in 11/2024 though she documented she had on the electronic medication administration record. She stated she was trained to administer medications as ordered. During a telephone interview on 05/18/25 at 4:44 PM with LVN C, it was revealed he observed Resident #16 during her seizure on 03/10/25. He stated he observed resident #16 shaking her extremities, resident #16 had her eyes rolled back, and that was observed for 1 minute and 38 seconds. LVN C stated Resident #16's arms were observed jerking but was not rigid. LVN C stated Resident #16's oxygen was monitored and dropped to a level 87% on room air until staff administered oxygen supplementation via nasal cannula. He stated he observed Resident #16 with a blank stare and observed unconsciousness. This was determined to be an Immediate Jeopardy (IJ) on 05/18/2025 at 5:11 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 05/18/2025 at 5:24 p.m. The following Plan of Removal submitted by the facility was accepted on 5/19/2025 at 5:00 p.m.: Interventions: The alleged perpetrator was terminated on. Completed on 5/12/2025. Self-report was completed to HHS by the administrator. Completed on 5/16/2025 Out of cycle QAPI including this plan was presented to the Medical Director by the facility administrator. The medical director did not request changes to the plan. Completed 5/16/2025 Implemented daily count of all anticonvulsant medications to ensure doses are not missed, completion date 05/16/25 Medication error completed for the missed doses on affected resident, completed 03/10/25. Pharmacy Consultant notified. [NAME] notified 05/16/25 by regional nurse. Clarification order obtained from the attending Physician on 05/16/25. Anticonvulsant monitoring from 03/12/25 to 03/24/25 was conducted by the DON, no medication errors identified during that time frame. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medication Pass Evaluation for Med Aid B by the DON and designee on 03/12/25, 03/17/25, 03/24/25. Audit of Anticonvulsant therapeutic labs conducted between 04/17/25 and 04/21/25 by ADON. Med Passes conducted with licensed staff on 05/02/25, 05/15/25 and 05/17/25 by ADON and RN. DON or designee began daily EMAR monitoring on 05/17/25. DON or designee began anticonvulsant In-services: All new staff will be in-serviced during the facility orientation. No staff will be allowed to take a shift until in-service education is completed. The following in-services were initiated by the DON, ADON and regional nurse Completed on 05/16/25 Licensed Nurses and Medication Aides Medication administration Following Physicians orders. Anticonvulsant medication count Ensure that therapeutic levels are drawn as ordered. One to one in service for Administrator and DON on following policies and procedures to prevent abuse and neglect. Completed by ADO on 5/16/2025 @ 7:44pm Monitoring of the facility's plan of removal included the following: During an interview on 05/20/2025 at 9:57 am with LVN C, he stated that not administering medications to residents as per doctors' orders was considered neglect and would report it to the Abuse Coordinator and DON immediately. He stated that nurses could confirm if medications were being administered by med aides by looking at the count sheet and by reviewing the MAR. During an interview on 05/20/25 at 10:00 AM with Resident # 45, he stated he liked living at the facility and said staff treated him with respect and dignity. Resident # 45 said he always got his medications supervised every day and had not had issues with running out of medications. During an interview on 05/20/25 at 10:00 AM with LVN AA revealed she was aware of the Abuse coordinator who was the Administrator. She stated there was a new policy for only nurses to administer anticonvulsants as ordered. She stated not administering medications as ordered would be considered neglect and she would report that concern or allegation to the Abuse Coordinator immediately. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/20/2025 at 10:11AM with RN S revealed that the facility provided training on not administering medications to residents as per doctors' orders was considered neglect and would report it to the Abuse Coordinator and DON. He stated that nurses could confirm if medications were being administered by med aides by looking at the count sheet and by reviewing the MAR. He stated that if medaids' have questions they knew to come to him and ask for clarification. During an interview on 05/20/25 at 10:27 AM with ADON K revealed the facility provided training on reporting allegations of Abuse, Neglect, and Exploitation immediately to the Abuse Coordinator, who was the Administrator. She stated if the Abuse Coordinator was not at the facility, she would be able to obtain his phone number located outside the Human Resources office or by the front desk. She stated if he were not available, the next person to notify was the DON immediately. ADON K stated nurses were responsible for administering medications as ordered. She stated nurses could confirm medications were administered as ordered by confirming with the MAR and the count sheet. She stated medications that were not administered as ordered was neglect and it was to be reported to the physician, DON, and the Abuse Coordinator. During an interview on 05/20/25 at 10:45 AM with the DON stated the Regional Compliance Nurse and the ADON's would monitor medication administration weekly to ensure it was administered as ordered. ADON's will be doing random medication passes with Medication Aides. She stated she received in-service training in reporting Abuse, Neglect, and Exploitation within a 2-24-hour timeframe to the Abuse Coordinator. She stated she was aware that the Abuse Coordinator's contact information was located by the Human Resources office and the front desk. She stated if he was not available, she would be responsible for reporting it to HHSC and initiate an investigation. During an interview on 05/20/25 at 10:47 AM with CNA P revealed she had been trained in how to report ANE on 5/19/25. She stated she would report it to the abuse prohibition coordinator or the administrator. CNA P said she could find his contact information in the lobby of the facility and in the room where the staff clocked in. She said if she was not able to communicate with the administrator, she would report to the DON or ADON and also call the state. CNA P said suspicions of ANE had to be reported immediately. She stated that regarding anticonvulsant medications, only the nurses were able to supervise them. During an interview on 05/20/25 at 10:51 AM with LVN I revealed she had been trained on 5/19/25 and in 5/20/25 on how to report ANE. She stated she had to report it immediately to the abuse prohibition coordinator and if he was not available, she would immediately report it to the DON and ADON. She said the contact information for reporting could be found in the hallways of the facility and in the lobby or front entrance. She stated only nurses were able to administer anticonvulsant medications. During an interview on 05/20/25 at 10:56 AM with med aid U revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation immediately to facility administrator as he was Abuse Coordinator. She stated that his contact information was posted outside of the human recourses office and at the front desk when entering the building. Med Aide T stated that if the Abuse Coordinator was not available, she would notify DON immediately. She stated that not administering medications to residents as per doctors' orders was considered neglect and would report it to the Abuse Coordinator and DON. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/20/25 at 10:58 AM with CNA Q revealed she had been in-serviced on how to immediately report ANE either to the state number or to the abuse prohibition coordinator and to the DON and ADON if she was not able to communicate with the administrator. CNA Q said she could find the contact information for the state and the abuse coordinator in the hallways from the facility and in the lobby at the front entrance. CNA Q said only nurses were able to supervise anticonvulsant medications and that she had been in-serviced on the administration of that medication in the last training provided on 5/19/25. During an interview on 05/20/25 at 11:04 AM with CNA V revealed that the facility provided training on reporting allegations of Abuse, Neglect and Exploitation immediately to facility administrator as he was Abuse Coordinator. She stated that his contact information was posted outside of the human recourses office and at the front desk when entering the building. CNA V stated that if the Abuse Coordinator was not available, She would notify DON immediately. During a telephone interview at 05/20/25 at 11:21 AM with LVN BB revealed he was trained to report allegations of Abuse, Neglect, and Exploitation immediately to the Abuse Coordinator. He stated the Abuse Coordinator was the Administrator and his contact information was located outside the Human Resources office and by the front desk. He stated that if the Abuse Coordinator was not available, he would report it to the DON immediately. He stated if staff were to intentionally not administer medication as ordered but documented on the electronic medication administration record as administered, that was Neglect and to be reported to the Abuse Coordinator immediately Record review of Medication Aide A's discharge documentation for date of infractions noted 03/08/25-03/09/25, and Medication Aide A failed to administer Keppra to prevent seizures and falsely documented it on 03/08 and 03/09, 2nd offense termination requested. Document signed by the Administrator and the DON, dated 03/10/25. Record review of Medication Aide B's counseling document dated 03/10/25 for failed to adhere to corporate code of conduct and job duties. It noted Medication Aide B failed to administer to administer medication and falsified documentation stated that medication was given on days 03/08/25 and 03/09/25. Record review of medication pass observations completed by the DON while observing Medication Aide B 3/24/25, 03/12/25, 03/17/25, 03/24/25, to verify that he was administering medications according to doctors' orders and no concerns were identified during the med pass observation . Record review of anticonvulsant medication's were accounted of by ADONs dated 05/16/25. No issues noted. Record review of medication pass of various staff by the ADON's dated 05/02/25, 05/15/25, and 05/17/25. Record review of facility policy Medication Administration and general Guidelines, with no date, read in part: Medications are administered as prescribed, in accordance with State regulations using good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of the attending physician. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Administrator was informed that the IJ was removed on 05/20/2025 at 12:30 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Deficiency Text Not Available

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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. Deficiency Text Not Available