| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455731 | A. Building<br>B. Wing | 01/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Advanced Health & Rehab Center of Garland | 1201 Colonel Drive<br>Garland, TX 75043 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 1 of 10 residents (Resident #1) reviewed for baseline care plans. The facility failed to develop a baseline care plan within 48 hours of Resident #1's admission to the facility on [DATE] that addressed the resident's pain management needs while on hospice services for an end-stage diagnoses of malignant cancer of the breast, liver, bone, and bile ducts. As a result, she experienced on-going, excruciating pain from 12/26/25-01/04/26. This failure could place residents at risk of not having their individual care needs met in a timely manner, diminished quality of life, and unnecessary pain and suffering.Findings included: Record review of Resident #1's face sheet dated 01/04/26 reflected a [AGE] year-old female with diagnoses that included Malignant Neoplasm of Central Portion of Right Female Breast (Right Breast Cancer), Malignant Neoplasm of Liver (Cancer in the liver) and Intrahepatic Bile Duct (Cancer in the bile ducts inside the liver), Malignant Neoplasm of Bone (Cancer in the bone), Unspecified Pain, Depression, and Other Chronic Pain. Record review of Resident #1's Entry MDS dated [DATE], indicated she admitted to the facility on [DATE]. Record review of the MDS indicated the BIMS was not completed. Record review of Resident #1's Comprehensive Care Plan dated 01/04/26 reflected, Focus: Communication (Impaired): Resident has a communication problem related to Goal: Resident will have needs met in a timely manner, dignity will be maintained, and current level of functioning will be maintained. Interventions: Provide information to resident/family about community resources: (Associations for the blind) for further adaptive devices: (talking clocks and calendars, interpreter services). Record review of the facility's EHR further revealed that Resident #1 did not have a finished Baseline or Care Plan completed. The baseline care plan had been started but contained no information about Resident #1's pain or receiving hospice services. Record review of Resident #1's Initial Pain assessment dated [DATE] reflected the resident had, .3b1. Breathing - independent of vocalization: 1) Occasional labored breathing. Short periods of hyperventilation. 3b2. Negative vocalization: Repeated troubled calling out. Loud moaning or groaning. Crying. 3b3. Facial expression: 2) Facial Grimacing. 3b4. Body language: 1) Tense. Distressed pacing. Fidgeting. 3b5. Consolability: 0) No need to console. Pain assessment further revealed a pain score of 6 with generalized body pain and resident's acceptable level of pain as 0. Record review of Resident #1's progress note on 12/26/25 at 7:03 PM: Patient 48 Y/O female patient admitted from home for respite stay via stretcher by two transporters under the care of [Facility MD] with diagnosis of Malignant neoplasm of right breast. Head to toe assessment completed, patient confused and disoriented unable to answer any question but crying. Patient is restless and unable to control he body. Patient is already under [Hospice company] who came and admitted patient. [Facility MD] notified, and he said OKAY to continue with hospice orders.<br><br>(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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 01/04/26 at 9:30 AM reflected Resident #1 was lying in bed. Resident #1 was observed to be thrashing around the bed, crying and moaning. Resident #1 was clenching teeth with facial grimacing noted. Resident #1 did not console, respond to name or answer any questions. Interview and observation on 01/04/26 at 10:38 AM reflected LVN A standing in front of Resident #1's room. LVN A stated he was going to give her medication because she was crying. LVN A stated she usually cries because she had breast cancer that had spread and was in pain, but even after he gives Resident #1 the medications, she would still cry because it was not effective. LVN A stated the morphine was as needed every 1-2 hours. Observation revealed LVN A repositioning Resident #1. Resident #1 noted to be writhing, crying, and moaning. Resident #1 had facial grimacing and tense jaw. Symptoms were noted to worsen with movement. Observation revealed LVN A giving Resident #1 0.25 mL of morphine. Observation on 01/04/26 at 12:06 PM revealed Resident #1 resting. At 12:07 PM Resident #1 was back awake. Upon awaking, she was thrashing and writhing around the bed, while moaning and crying. Resident #1 was very tense and grimacing. Observation on 01/04/26 at 12:20 PM of incontinent care for Resident #1 with CNA B and CNA C. Resident #1 was crying, writhing around bed with facial grimacing prior to incontinent care. During the incontinent care, Resident #1 was screaming with any touch and when being wiped. Interview on 01/04/26 at 1:35 PM with CNA B revealed it was her first day caring for Resident #1. CNA B stated it seemed like Resident #1 was in a lot of pain. She stated with incontinent care, she was moving all over the bed and screaming. CNA B also stated that Resident #1 had been grimacing, restless and crying. CNA B stated she was not sure where the pain was coming from because Resident #1 was unable to communicate. CNA B stated she did report to LVN A earlier that Resident #1 was in pain. CNA B stated she was not sure what LVN A did, but he did put something in Resident #1's mouth. CNA B stated even after the medication, Resident #1 was still moaning, and she was unable to tell if the medication was effective. CNA B revealed Resident #1 would only sleep for short periods and then start moving around and moaning again. Interview on 01/04/26 at 1:48 PM with CNA C revealed she had been working with Resident #1 since she was admitted to the facility. CNA C stated Resident #1 was always crying. CNA C stated she asked a nurse yesterday why Resident #1 was crying because she would scream and cry every time she was changed. CNA C stated the nurse told her it was due to Resident #1's cancer. CNA C stated she was notifying the nurse when she saw Resident #1 cry. She stated the non-verbal signs of pain were crying, screaming, and moving around. CNA C stated the nurse gave her medications, but she still cried after receiving them. CNA C stated she was not sure if the medications were effective because she was unsure exactly when they were given. She stated Resident #1 just cried a lot. CNA C stated Resident #1 had been crying ever since arriving at the facility. CNA C stated she just assumed it was a mental issue that caused her to cry so much. Observation and interview on 01/04/26 at 2:15 PM revealed Resident #1 tossing and turning in bed. Resident #1 was also moaning and grimacing. Resident #1's Family member #3 noted to be at bedside. Family member #3 stated she had visited a few times since the resident came to the facility. Family member #3 stated she was in pain which was why Resident #1 was crying. She stated when Resident #1 was home, she only started to cry when the pain got worse. Family member #3 stated at that point she was still alert and could tell you when she was in pain. Family member #3 stated she feels the facility was not managing her pain because Resident #1 had been like this every time she had visited. Family member #3 stated she would like the facility to care more so Resident #1 was not writhing and constantly in pain. She stated Resident #1 had stage 4 cancer and it was continuing to get worse. Family member #3 stated facility staff were coming in to check on her, but they just glanced into the room and did not perform a full assessment. She stated she would like the staff to have had more compassion for Resident #1 because<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | it was not her fault she had cancer. Family member #3 stated the Friend had no POA and should not make any decisions. Family member #3 stated she heard the Friend was telling staff to not give medications. Family member #3 stated she would like Resident #1 to be pain free and comfortable. Observation and interview on 01/04/26 at 3:48 PM revealed Resident #1 moaning, groaning, crying, and had facial grimacing. Family Member #3 stated she was just given morphine, but it did not seem to be working. Family Member #4 stated Resident #1 had been crying every time he visited. Interview on 01/04/26 3:48 PM revealed LVN A gave Resident #1 0.5 mL of morphine around 3:25 PM. Interview on 01/04/26 at 4:21 PM with the DON revealed Resident #1 started at the facility for respite care, but then shortly switched to staying at the facility full-time. The DON stated Resident #1 had metastatic breast cancer and currently had 2 cancer spots coming out of her skin. The DON stated Resident #1 had been in a lot of pain, so she had been in contact with hospice to change orders to make her more comfortable. The DON stated Resident #1 was transitioning and imminent. The DON stated when she visited Resident #1 she had just received pain medications and was still crying out for more. The DON stated she contacted hospice, and they were coming out to assess and change orders. The DON stated Resident #1 no longer had mild pain due to the cancer being far along. The DON stated Resident #1's pain was always severe. The DON stated there was no pain management in the baseline care plan for Resident #1. She stated it was all nurses' responsibility to ensure the baseline care plan completed. She stated her expectation was that residents received a thorough assessment on admission which would include pain and hospice services included on the baseline care plan. Interview o n 01/04/26 at 4:41 PM with The Administrator revealed when Resident #1 admitted , she was aware she had cancer. The Administrator stated she would expect pain to be on Resident #1's baseline care plan and she did not see it care planned. The Administrator stated the risk of not managing residents' pain was a decreased quality of life. Observation on 01/04/26 at 5:33 PM with LVN A revealed that he was administering morphine (0.5 mL) and lorazepam to Resident #1. Resident #1 observed to be awake and restless. Interview on 01/04/25 at 6:32 PM with the Hospice nurse at the facility, she stated hospice was notified and starting the process for a Crisis Care nurse (provides immediate, intensive, short-term nursing care 24 hours/day) to come and be at Resident #1's bedside. She stated they were working on getting a nurse staffed. The Hospice Nurse stated she updated the morphine orders to one order instead of the range. Interview on 01/05/26 at 9:42 AM with The Friend revealed he had been with Resident #1 since she was living at home. He stated the first day he saw her after she arrived at the facility, she was pulling her shirt off and moving around a lot. He stated she had been crying a lot because she had crusties in her eyes that took a while to clean out. The Friend stated he wanted the staff to feed her more, but he felt they were only giving her morphine. He stated the staff did not seem to understand that she needed them to do everything for her. He stated that the morning of 01/03/25, the hospice nurse came and stayed with him until 3 am. The Friend stated she would be screaming in pain, and the door would just be shut. He stated the morphine would make her sleep, but it never lasted long, and she would wake back up groaning and crying. He stated Resident #1 would cry frequently. The Friend stated one day he came to the facility and Resident #1 was crying and it was heard all the way down the hall. He said she was screaming and crying in pain most of the time while she was at the facility. The Friend stated the facility called him on 01/04/26 and he received an update from the Administrator, but he was unable to come to the facility until 01/05/26. Interview on 01/05/26 at 11:03 AM with LVN K revealed all new admissions to the facility received an initial assessment and that determined if the resident had any pain. He stated if they did not show signs, staff must assess the residents for any non-verbal signs. LVN K stated he would review the baseline care plan if he did not do the<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | initial assessment on a new resident. He stated the baseline care plan was where they got the orders from, so it was especially important that if a resident had pain that it was put on the baseline care plan because it gives staff a regimen to follow. He stated it was especially important for hospice residents to coordinate care. LVN K stated the risk of not having pain included on the baseline care plan was not effectively managing a resident's pain. Interview on 01/05/26 at 11:26 AM with CNA D revealed she reviewed care plans on every new resident with the nurse. She stated she would expect pain to be on the care plan because it was how she was notified if a resident required pain medications prior to care. Interview on 01/05/26 at 11:30 AM with ADON M revealed that she expected baseline care plans to be completed on all residents . ADON M stated that pain would absolutely need to be included in the baseline care plan. ADON M stated it is all nurses' responsibility to ensure the baseline care plan is completed. She stated it was important to have pain included so that all staff knew how to care for the residents and what interventions to complete. ADON M stated if pain were not included, it could result in the residents' pain not being managed. Interview on 01/05/26 at 11:45 AM with LVN L revealed that pain should be in the baseline care plans. LVN L stated it was important to include pain because that was how he knew to control the pain. LVN L stated that without pain care planned, the residents could have uncontrolled pain. Interview on 01/05/26 at 12:13 PM with LVN U revealed that baseline care plans were completed by the nurse on admission . LVN U stated she expected pain in the care plan if it was an issue for the residents. She stated it was important so staff could control the residents' pain. LVN U stated the baseline care plan provided levels and interventions to complete to ensure the pain was being managed. LVN U stated that without pain being on the baseline care plan, it put the resident at risk for unmanaged pain. She stated the pain could also affect the aides and their ADL care. LVN U stated Resident #1 should have had pain included on the baseline care plan. Interview on 01/05/26 at 12:38 PM with ADON N revealed that pain should be included in the baseline care plan if it was an issue. ADON N stated it was important for it to be included so the staff know how to care for the residents and be aware of the residents' baseline. ADON N stated the nurse who admitted the resident and performed the initial assessment, typically completed the baseline care plan. He stated if pain was not on the care plan, it was hard for the nurses to know exactly what was going on with the resident and how to help. ADON N stated the pain could not be managed as well. ADON N stated he was not sure why Resident #1 did not have a baseline care plan. He stated it was missing when she admitted . Interview on 01/05/26 at 12:50 PM with the DON revealed Resident #1's baseline care plan was not triggered when she started at the facility for respite care. The DON stated staff started one, but it was never completed. She stated the baseline care plans gave the plan of care and what to do if there was pain. The DON stated it gave interventions to start with and help manage the symptoms. She stated that the care plan should be updated with changes. The DON stated the baseline care plans helped ensure that symptoms were more managed, and guided the staff. The DON stated the risk of not including pain on the baseline care plan was unmanaged pain and symptoms. Interview on 01/05/26 at 2:07 PM with RN O revealed she had completed baseline care plans. She stated if the resident had any pain, it should be included in the baseline care plan. RN O stated including pain ensured the resident received interventions and the whole staff was aware of the resident's situation. RN O stated if it were not on the care plan, it could affect the plan of care, and directly affect the residents and family. She stated it put the residents at risk of not receiving proper or adequate care. Interview on 01/05/26 at 3:47 PM with The Administrator revealed Resident #1's baseline care plan was not completed. The Administrator stated the baseline care plan should be completed on all admissions by the nurse. She stated the baseline care plan was important<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | because it gave staff an idea of how to care for the residents. The Administrator stated not having pain on the baseline care plan put the residents at risk of not receiving effective interventions. Record review of the facility's Baseline Care Plans, revised 04/02/25 reflected: Policy: Resident person-centered baseline care plans are developed and implemented for new admission residents. Fundamental Information: Resident person-centered baseline care plans communicate fundamental care approaches and goals for resident related clinical diagnosis, identified concerns and as a result of the admission evaluation/assessment of each healthcare discipline. The baseline care plans are inclusive to support effective individualized resident care that meet professional standards of quality care and services Baseline care plans are developed and implemented within 48 hours of a resident new admission. The baseline care plans include measurable objectives to address the resident's immediate medical, clinical, functional, mental, and psychosocial person-centered needs. Baseline care plans are developed by Registered Nurses and other healthcare team members. The LVNs and other healthcare team members execute baseline care plans. Overall care coordination of the resident is evaluated by the DON/designee. Process: 1. The baseline care plans will be developed and implemented from minimum healthcare information necessary to properly care for a resident including but not limited to initial goals based on admission orders, admission evaluation/assessments, physician orders, dietary orders, therapy services, social services, and resident choices. 2. Obtain information and input from the resident, resident's family, surrogate or representative, to develop baseline care plans that includes measurable objectives to meet a resident's medical, nursing, mental and psychosocial needs .5. Baseline care plans may be implemented as an Acute Care Plan. |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and observations, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 7 residents (Resident #1) reviewed for pain management. The facility failed to provide Resident #1, who was on hospice services for end-stage cancer to the breast, liver, bone, and bile ducts, with effective pain management from 12/26/25 through 01/04/26. The facility did not reevaluate, advocate, or provide the full amount of pain medication available as allowed by physician's orders for appropriate pain management. This failure resulted in Resident #1 exhibiting non-verbal signs of excruciating pain to include screaming during care, crying, thrashing/writing in bed, and moaning. An IJ was identified on 01/04/26. The IJ Template was provided to the facility on [DATE] at 5:15 PM. While the IJ was removed on 01/05/26, the facility remained out of compliance at a scope of isolated and severity of no actual harm with 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. This failure could place residents at risk of prolonged and unnecessary pain and suffering, and a decreased quality of life. Findings included: Record review of Resident #1's face sheet dated 01/04/26 reflected the resident was a [AGE] year-old female with diagnoses that included malignant neoplasm of central portion of right female breast (right breast cancer), malignant neoplasm of liver (cancer in the liver) and intrahepatic bile duct (cancer in the bile ducts inside the liver), malignant neoplasm of bone (cancer in the bone), unspecified pain, depression, and other chronic pain. Record review of Resident #1's Care Plan dated 01/04/26 reflected: Focus: Communication (Impaired): Resident has a communication problem related to Goal: Resident will have needs met in a timely manner, dignity will be maintained, and current level of functioning will be maintained. Interventions: Provide information to resident/family about community resources: (Associations for the blind) for further adaptive devices: (talking clocks and calendars, interpreter services). Record review of the facility's EHR further revealed that Resident #1 did not have a finished Baseline or Care Plan completed.Record review of Resident #1's Initial Pain assessment dated [DATE] reflected the resident had: .3b1. Breathing - independent of vocalization: 1) Occasional labored breathing. Short periods of hyperventilation. 3b2. Negative vocalization: Repeated troubled calling out. Loud moaning or groaning. Crying. 3b3. Facial expression: 2) Facial Grimacing. 3b4. Body language: 1) Tense. Distressed pacing. Fidgeting. 3b5. Consolability: 0) No need to console. Pain assessment further revealed a pain score of 6 with generalized body pain and resident's acceptable level of pain as 0. Record review of Resident #1's progress note on 12/26/25 at 7:03 PM reflected: Patient 48 Y/O female patient admitted from home for respite stay via stretcher by two transporters under the care of [Facility MD] with diagnosis of Malignant neoplasm of right breast. Head to toe assessment completed, patient confused and disoriented unable to answer any question but crying. Patient is restless and unable to control he body. Patient is already under [Hospice company] who came and admitted patient. [Facility MD] notified, and he said OKAY to continue with hospice orders. Record review of Resident #1's progress notes on 12/26/25 at 7:04 PM reflected the resident received a PRN dose of morphine sulfate oral solution (liquid morphine). At 7:28 PM, the follow-up pain scale was 4. Record review of Resident #1's physician's orders on 12/26/25 reflected the following: Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML (Morphine Sulfate) *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for SOB/PAIN. Record review of Resident #1's progress notes on 12/31/25 reflected that new orders were received from the hospice company and the morphine (narcotic pain<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | medication) and lorazepam (anxiety medication) orders were updated to be given routinely. Record review of Resident #1's Physician's orders reflected the following: Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML. Give 0.25 ml by mouth every 4 hours for pain every four hours.Record review of Resident #1's progress notes on 01/03/26 at 1:42 AM reflected the following: Hospice nurse at bedside to assess resident. Hospice nurse spoke with resident's [Friend] regarding resident's condition and POC. New hospice orders:1.DC routine morphine and Ativan.2.Start morphine 20mg/ml 0.25-1.0ml q 1 h PRN; anxiety/agitation. Record review of Resident #1's MAR reflected Resident #1 had no ordered breakthrough or long-acting pain medications. Record review of Resident #1's EHR reflected there were no pain assessments completed.Record review of Resident #1's progress notes revealed there was no documentation indicating the physician or hospice was notified when Resident #1 displayed signs of pain. Record review of Resident #1's Narcotic logs revealed she received the following morphine doses: 12/26/25: 0.25 ml at 7:28 PM 12/27/25: 0.25 ml at 10:00 AM, 0.25 ml at 1:00 PM, 0.25 ml at 5:00 PM, 0.25 ml at 9:30 PM12/28/25: 0.25 ml at 8:00 AM, 0.25 ml at 1:00 PM, 0.25 ml at 6:00 PM, 0.25 ml at 10:15 PM12/29/25: 0.25 ml at 4:00 AM, 0.25 at 12:00 PM, 0.25 ml at 8:38 PM12/30/25: 0.25 ml at 1:00 AM, 0.25 ml at 4:00 AM, 0.25 ml at 6:30 AM, 0.25 ml at 8:15 PM, 0.25 ml at 10:15 PM12/31/25: 0.25 ml at 12:00 AM, 0.25 ml at 4:00 AM, 0.25 ml at 6:00 AM, 0.25 ml at 9:00 AM, 0.25 ml at 4:00 PM, 0.25 ml at 6:00 PM, 0.25 ml at 8:00 PM01/01/26: 0.25 ml at 12:00 AM, 0.25 ml at 4:00 AM, 0.25 ml at 8:00 AM, 0.25 at 12:00 PM, 0.25 ml at 2:00 PM, 0.25 ml at 4:00 PM, 0.25 ml at 8:00 PM01/02/26: 0.25 ml at 12:00 AM, 0.25 ml at 4:00 AM, 0.25 ml at 6:00 AM, 0.25 ml at 12:00 PM, 0.25 ml at 4:00 PM, 0.25 ml at 11:55 PM 01/03/26: 0.25 ml at 8:00 AM, 0.25 ml at 10:05 AM, 0.25 ml at 1:00 PM, 0.25 ml at 5:00 PM, 0.25 ml at 11:00 PM01/04/26: 0.25 ml at 7:00 AM, 0.25 ml at 10:35 AM, 0.5 ml at 12:25 PMObservation on 01/04/26 at 9:30 AM reflected Resident #1 was lying in bed. Resident #1 was observed to be thrashing around the bed, crying and moaning. Resident #1 was clenching her teeth with facial grimacing noted. Resident #1 was not able to be consoled, respond to name, or answer any questions. Observation on 01/04/26 at 10:10 AM reflected Resident #1 was crying and writhing in bed. Resident #1 was not answering any questions. Interview and observation on 01/04/26 at 10:38 AM reflected LVN A standing in front of Resident #1's room. LVN A stated he was going to give her medication because she was crying. LVN A stated Resident #1 usually cried because she had breast cancer that had spread and was in pain. LVN A also stated that even after he gave Resident #1 the medication, she would still cry because it was not effective. LVN A stated the morphine was as needed every 1-2 hours. LVN A was observed repositioning Resident #1. Resident #1 noted to be writhing, crying, and moaning. Resident #1 had facial grimacing with a tense jaw. Symptoms were noted to worsen with movement. LVN A was observed giving Resident #1 0.25 mL of morphine. Interview on 01/04/26 at 11:34 AM with Resident #1's Hospice Nurse revealed she was familiar with Resident #1. The Hospice Nurse stated she had been caring for Resident #1 frequently and she had been in pain. The Hospice Nurse stated her morphine was started routine to help manage Resident #1's pain. However, the Hospice Nurse reported that Resident #1's Concerned Party was struggling with the death process and got upset with the facility medicating Resident #1. The Hospice Nurse stated that Resident #1 did not have a POA, but they had been trying to navigate respecting the Concerned Party's wishes and keeping Resident #1 comfortable. The Hospice Nurse stated the morphine order was changed to PRN to make the Friend less upset with facility staff. The Hospice Nurse stated that Resident #1 had been crying and moving around the bed since she arrived at the facility. Observation on 01/04/26 at 12:06 PM revealed Resident #1 resting. At 12:07 PM Resident #1 was back awake. Upon awaking, she was thrashing and writhing around the bed, while moaning and crying. Resident #1 appeared to be very tense and grimacing. Observation on 01/04/26 at 12:20<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | PM of incontinent care for Resident #1 with CNA B and CNA C. Resident #1 was crying, writhing around bed with facial grimacing prior to incontinent care. During the incontinent care, Resident #1 was screaming with any touch and when being wiped. Interview on 01/04/26 at 1:18 PM with LVN A revealed that non-verbal signs of pain were groaning, moving around a lot, and turning. LVN A stated Resident #1 had exhibited all those signs. LVN A stated Resident #1 was on hospice services and was unable to communicate. LVN A stated he read Resident #1's body language which revealed she was uncomfortable. He stated he was not present when the morphine order was changed, but he was aware it was routine and changed to PRN. LVN A stated the current morphine order was 0.25 - 1 mL every one-hour PRN. LVN A stated at one point he felt that 0.25 mL was effective which was why he gave that dose. He stated when he gave the 0.25 mL, she relaxed but it never lasted long. LVN A stated last week she would be screaming and crying, then sleep and then wake back up shortly after. LVN A was unable to specify the exact time. LVN A stated on 01/04/26, the 0.25 mL had not been working, so he stated he just gave a 0.5 mL dose, but it was still ineffective. LVN A stated he was charting the morphine in the narcotic book, not on the MAR. He stated he had spoken with his supervisor and contacted the hospice nurse and she was coming to visit. He stated he had not spoken to the MD because she was on hospice and they managed her orders. LVN A stated the CNAs were reporting to him that Resident #1 was in pain. He stated she did not receive any other pain medications; only the morphine. He stated he had been assessing Resident #1's pain every 30-60 minutes, but did not chart it. He stated that morning her pain level was 7. Interview on 01/04/26 at 1:35 PM with CNA B revealed it was her first day caring for Resident #1. CNA B stated it seemed like Resident #1 was in a lot of pain. She stated with incontinent care, Resident #1 was moving all over the bed and screaming. CNA B also stated that Resident #1 had been grimacing, restless, and crying. CNA B stated she was not sure where the pain was coming from because Resident #1 was unable to communicate. CNA B stated she did report to LVN A that Resident #1 was in pain. CNA B stated she was not sure what LVN A did, but he put something in Resident #1's mouth. CNA B stated even after the medication, Resident #1 was still moaning, and she was unable to tell if the medication was effective. CNA B revealed Resident #1 would only sleep for short periods, and then start moving around and moaning again. Interview on 01/04/26 at 1:48 PM with CNA C revealed she had been working with Resident #1 since she was admitted to the facility. CNA C stated Resident #1 was always crying. CNA C stated she asked a nurse yesterday why Resident #1 was crying because she would scream and cry every time she was changed. CNA C stated the nurse told her it was due to Resident #1's cancer. CNA C stated she was notifying the nurse when she saw Resident #1 cry. She stated the non-verbal signs of pain were crying, screaming, and moving around. CNA C stated the nurse gave her medications, but she still cried after receiving them. CNA C stated she was not sure if the medications were effective because she was unsure exactly when they were given. She stated Resident #1 just cried a lot. CNA C stated Resident #1 had been crying ever since arriving at the facility. CNA C stated she just assumed it was a mental issue that caused her to cry so much. Observation and interview on 01/04/26 at 2:15 PM revealed Resident #1 tossing and turning in bed. Resident #1 was also moaning and grimacing. Resident #1's Family member #3 was at her bedside. Family member #3 stated she had visited a few times since the resident came to the facility. Family member #3 stated she was in pain which was why Resident #1 was crying. She stated when Resident #1 was home, she only started to cry when the pain got worse. Family member #3 stated at that point, she was still alert and could tell you when she was in pain. Family member #3 stated she felt the facility was not managing her pain because Resident #1 had been like this every time she had visited. Family member #3 stated she would like the facility to care more so Resident #1 was not writhing and constantly in pain. She<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | stated Resident #1 had stage 4 cancer and it was continuing to get worse. Family member #3 stated the facility staff were coming in to check on her, but they just glanced into the room and did not perform a full assessment. She stated she would like the staff to have had more compassion for Resident #1 because it was not her fault she had cancer. Family member #3 stated the Concerned Party had no POA and should not make any decisions. Family member #3 stated she heard the Concerned Party was telling staff to not give her medications. Family member #3 stated she would like Resident #1 to be pain free and comfortable. Observation and interview on 01/04/26 at 3:48 PM revealed Resident #1 moaning, groaning, crying, and had facial grimacing. Family Member #3 stated she was just given morphine, but it did not seem to be working. Family Member #4 stated Resident #1 had been crying every time he visited. Interview on 01/04/26 at 3:48 PM revealed LVN A gave Resident #1 0.5 mL of morphine around 3:25 PM. Interview on 01/04/26 at 4:21 PM with the DON revealed Resident #1 started at the facility for respite care, but then shortly switched to staying at the facility fulltime. The DON stated she did not have a POA, but Family Member #3 was working on that. The DON stated Resident #1 had metastatic breast cancer and currently had 2 cancer spots coming out of her skin. The DON stated Resident #1 had been in a lot of pain, so she had been in contact with hospice to change orders to make her more comfortable. The DON stated there had been a dynamic between her Concerned Party and Family Members regarding her care. The DON stated Family Member #3 wanted Resident #1 to be comfortable and she was the one who could make decisions. The DON stated the Concerned Party did not want her to be sleepy and was concerned with Resident #1 not eating. The DON stated there was a lot of anger between the Concerned Party and the staff. The DON stated everyone processed grief differently, and Resident #1 was transitioning and imminent (actively dying). The DON stated when she visited Resident #1, she had just received pain medications and was still crying out for more. The DON stated she contacted hospice, and they were coming out to assess and change orders. The DON stated Resident #1 no longer had mild pain due to the cancer being far along. The DON stated Resident #1's pain was always severe. The DON stated the morphine order was confusing with the range, and she had asked hospice to change it to just one order. The DON stated she expected her staff to call hospice to come in and evaluate the resident for further pain medications if they were ineffective. The DON also stated she expected her staff to advocate for all the residents. The DON stated Resident #1's pain was not controlled because hospice and her staff were listening to what the Concerned Party wanted. The DON stated the risk of not managing pain was the residents could pass uncomfortable and be in pain. Interview on 01/04/26 at 4:41 PM with the Administrator revealed when Resident #1 admitted , she was aware she had cancer. The Administrator stated she was not involved in any of the direct care, but did receive a voicemail about Resident #1 on 01/03/25. The Administrator stated the voicemail was confusing, but she notified the DON and set up a care plan meeting with hospice. The Administrator said they planned to call hospice on 01/05/26 to set up the meeting. The Administrator stated her expectation was that pain was addressed by either contacting hospice or the physician. The Administrator stated the risk of not managing residents' pain was a decreased quality of life. Interview and observation on 01/04/26 at 5:33 PM with LVN A revealed that he was administering morphine (0.5 mL) and lorazepam to Resident #1. Resident #1 was observed to be awake and restless. LVN A stated he tried to call hospice again to get an ETA, but could only got ahold of the main line, and left a message for the nurse. Interview on 01/04/26 at 5:19 PM with the Hospice MD revealed that his experience was through the hospice nurses. He stated Resident #1 was admitted to facility due to increased pain and agitation at home. The Hospice MD stated the morphine was originally scheduled PRN to figure out her symptoms and what was needed to control her pain. He stated Resident #1 had a decline and stopped eating and<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | communicating shortly after arriving at the facility. He stated Resident #1 was crying, restless, and screaming out, so the medications were changed to routine. The Hospice MD stated as far as he was aware, the routine was maintaining her comfort. The Hospice MD stated Resident #1's Friend became concerned with her decline, and assumed it was due to the medication. The Hospice MD stated it was the natural death process, but the Concerned Party could not understand that. The Hospice MD stated the orders were changed to PRN to benefit the Concerned Party; not Resident #1. The Hospice MD stated the order was changed to PRN and the frequency was increased. He stated he wanted Resident #1 to continue receiving the medication, the staff were just to do an assessment prior to administration. The Hospice MD stated he expected Resident #1 to be comfortable and pain free. He stated she was transitioning and at the end of life. The Hospice MD stated he was not aware of any changes in Resident #1 since the medication order was changed on 01/03/26. Interview on 01/04/25 at 6:32 PM with the Hospice nurse at the facility, she stated hospice was starting the process for a Crisis Care nurse (provides immediate, intensive, short-term nursing care 24 hours/day) to come and be at Resident #1's bedside. She stated they were working on getting a nurse staffed. The Hospice Nurse stated she updated the morphine orders to one order instead of the range. Interview on 01/05/26 at 9:42 AM with Resident #1's Friend revealed he had been with Resident #1 since she was living at home. He stated the first day he saw her after she arrived at the facility, she was pulling her shirt off and moving around a lot. He stated she had been crying a lot because she had crusties in her eyes that took a while to clean out. Resident #1's Friend stated he wanted the staff to feed her more, but he felt they were only giving her morphine. He stated the staff did not seem to understand that she needed them to do everything for her. He stated that the morning of 01/03/25, the hospice nurse came and stayed with him until 3:00 AM. Resident #1's Friend stated he felt like she got too much morphine and that was why she was no longer with it. He stated that hospice changed the morphine order, so the facility staff had to assess Resident #1 first and not give it if she was sleeping. He stated Resident #1 was in pain because the facility staff did not even know what was wrong with her. Resident #1's Friend stated Resident #1 would be screaming in pain, and the door would be closed. He stated the morphine would make her sleep, but it never lasted long, and she would wake back up groaning and crying. He stated Resident #1 would cry a lot. He stated he wanted Resident #1 to be able to talk and say goodbyes to visitors, but she was either awake, moaning, and groaning, or sleeping. Resident #1's Friend stated one day he came to the facility, and Resident #1 was crying and it was heard all the way down the hall. He said she was screaming and crying in pain most of the time while she was at the facility.Record review of the facility's Pain Management policy, revised July 2015, reflected the following: Residents shall be assessed for factors that predispose to pain upon admission to the facility and subsequently thereafter according to the findings of the assessment. Residents shall receive treatment for pain relief as necessary and monitored for effectiveness. Fundamental Information Evaluate the resident for pain upon admission, during periodic scheduled assessments, and with change in condition or status (e.g., after a fall, with change in behavior or mental status). Identification and evaluation of a patient's response to the plan of care is necessary until it is determined that the patient's pain is resolved or meets the patient's goal for relief. Procedure Utilize the following process steps as a systematic approach for clinical pain management Evaluation: Initial screen (Nursing admission Evaluation), Pain Data Collection Tool, Minimum Data Set (MDS) Plan: Initial Plan of care, Establish pain management goals, Individualized patient interventions Implement: Patient and family education, Anticipated measuresMonitorPatient response to interventions: Pharmacologic, Adjuvant, Non-pharmacologic, Psychosocial Record review and revise Plan Treatment:A. Assessment and evaluation<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | by the appropriate members of the interdisciplinary team (e.g., nurses, practitioner, pharmacists, etc.) may include a. Asking the patient to rate the intensity of his/her pain using a numerical scale or a verbal or visual descriptor that is appropriate and preferred by the resident. b. Record review of the resident's diagnoses or conditions and any additional factors that may be causing or contributing to pain. c. Identifying key characteristics of the pain d. The resident's goals for pain management and his/her satisfaction with the current level of pain control e. The effectiveness of specific pharmacological, non-pharmacological and treatments used in the past to treat pain. Approach to Pain Management: 1. Evaluate - identify, anticipate events or circumstances that will trigger or cause pain. 2. Treat by pre medicating the patient prior to the pain trigger or cause 3. Prevent - implement pharmacological and non-pharmacological interventions to avoid pain experiences 4. Monitor- patient's response to pharmacological and non-pharmacological measures. 5. Report - to physician patient response to interventions. 6. Management - the goal of the pain treatment plan is to improve the patient's quality of life and activity of daily living by managing pain around the clock with pharmacological and non-pharmacological interventions.Record review of the facility's Coordination of Hospice Services, dated 04/21/21, reflected: Policy: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff to promote the resident's highest practicable physical, mental, and psychosocial well-being.Policy Explanation and Compliance Guidelines: .2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible.4. The facility will monitor and evaluate the resident's response to the hospice care plans.5. The hospice will maintain communication with the facility as it related to the resident's plan of care and services to ensure each entity is aware of their responsibilities.6. The plan of care will include directives for managing pain and other uncomfortable symptoms and will be revised and updated as necessary.7. The facility will monitor for medications and medical supplies to ensure they are provided by hospice as indicated in the plan of care for palliation and management of the terminal illness.9. The facility will immediately contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations. The Administrator and DON were notified on 01/04/26 at 5:15 PM that an IJ had been identified and an IJ template was provided. The Administrator and DON were asked to provide a Plan of Removal.The following Plan of Removal was accepted on 01/05/26 at 10:05 AM: Plan of Removal - F697 - Pain Management1. Immediate actions (initiate 01/04/26): Charge Nurse/DON/designee immediately assessed pain using appropriate tool (0-10 scale if able; PAINAD/non-verbal tool if unable) and documented signs/symptoms and current comfort level. Facility immediately contacted hospice nurse and attending/medical provider to report uncontrolled pain episodes and frequency of distress behaviors documented on 01/04/26. Facility obtained clarified, complete medication orders from prescriber/hospice that include clear administration parameters (e.g., which dose to give under which conditions) and documented these orders per policy. Facility updated the care plan to reflect end-of-life comfort needs, pain assessment frequency, medication administration/reassessment expectations, and hospice coordination. Facility implemented enhanced monitoring until pain controlled: pain checks and comfort rounds at least hourly, with reassessment after each intervention and documentation of effectiveness. Completion date: 01/04/26-01/05/26 (same day/within 24 hours)2. How the facility will identify other residents having the potential to be affected and take corrective actionFacility-wide review (initiate 01/04/26;<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | complete 01/05/26): DON/Designee will run a list of:o All residents on hospice, [NAME] All residents with active opioid PRN range orders and/or recent pain complaints. For each identified resident, licensed nurse/designee will audit for:o Presence of complete parameters on PRN/range orders (no range without direction),o Pain assessment and reassessment documentation after PRN administration,o Evidence of provider/hospice notification for uncontrolled pain,o Care plan alignment with pain management needs. Any orders lacking parameters will be held for clarification (facility will contact provider/hospice promptly) and residents will be assessed and managed per hospice/provider direction.3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recurA. Process Changes (effective 01/05/26)1. PRN Range/Opioid Order Parameter Requiremento Facility will not accept or implement range/variable dose orders (e.g., 0.25/0.5/0.75/1.0 ml) without written parameters from prescriber/hospice (how to choose dose, frequency limits, reassessment expectations, and any hold criteria).o Orders missing parameters trigger an automatic provider/hospice clarification call and documented follow-up.2. Uncontrolled Pain Escalation Pathwayo If pain is not relieved after interventions or distress behaviors persist, staff must notify hospice/provider according to defined escalation triggers (facility-defined triggers included in policy such as repeated PRN use, persistent severe pain behaviors, or frequent crying/screaming).o Hospice residents: facility will use a Hospice Symptom Escalation Call Log to document time of call, who was contacted, response received, and new orders.B. Documentation Standards (effective 01/05/26) Pain must be documented:o Every shift and with any complaint/behavior suggestive of pain,o Before PRN administration (baseline),o Reassessed after medication/intervention within facility policy timeframe,o Effectiveness documented and, if ineffective, escalation documented.Completion date for systemic rollout: 01/05/263. Staff Education / Competency Training topics (complete by 01/5/26): Pain assessment (including non-verbal pain tools) End-of-life comfort care expectations in SNF + hospice coordination PRN opioid documentation and reassessment standards Clarifying incomplete orders / range dose parametersWho: All licensed nurses before shift via quick in-service, Staff unavailable to attend in service on 1/5/26 will receive personalized education and posttest prior to assuming their duties. Verification: Sign-in sheet + 5-question post-test 4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recurAudits/MonitoringAudit Tool: Pain Management & Hospice Coordination Audit (licensed nurse audit)What will be monitored: PRN opioid/range orders include parameters Pain assessment completed and documented Reassessment documented after each PRN Evidence of hospice/provider notification when pain uncontrolled Care plan reflects pain needs and hospice involvementFrequency: Weekly x 4 weeks, then Monthly x 2 months, then Quarterly Responsible party: DON/ADON/Designee; unit managers for follow-upReporting: Results reviewed in QAPI and trends/actions documented.5. What QA (Quality Assurance) committee will do to oversee compliance QAPI will review audit results, identify patterns (e.g., missing parameters, missed reassessments, delays calling hospice/provider), and implement additional actions (targeted re-education, disciplinary action if warranted, EMR prompts, staffing workflow changes). The surveyor monitored the facility's implementation of the accepted Plan of Removal on 01/05/26, which revealed the following: During interviews on 01/05/26 from 11:26 AM-3:58 PM, CNA D, CNA E, CNA F, MA I, CNA G, CNA H, MA J, from different shifts, stated they were all in-serviced on pain management before working their shifts. The CNAs verbalized the signs and symptoms of non-verbal pain and their plan of action if any residents notified them or appeared in any pain. Their plan of action included notifying the nurse immediately and ensuring the residents were treated for pain prior to any care. During interviews on 01/05/26 from 11:03 AM-4:04 PM, LVN K, LVN L, LVN U, RN O, RN P, RN Q, LVN R, RN S, from different shifts stated they had<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | been in-serviced on pain management and hospice care prior to their shifts. These LVNs and RNs verbalized how to assess pain in residents, which included non-verbal pain indicators. All verbalized what to do if a resident had pain, how to assess, medicate, reassess, and notify hospice/physician if medications were ineffective. Nurses also verbalized appropriate medication orders, clarifying with the physician as needed, and ensuring the baseline/care plans were updated and corrected as needed. Record review of facility's in-service records , dated 01/04/26 and 01/05/26, and titled Pain Management And Baseline Care Plan reflected the DON provided an in-service training on the following topics: PRN medications given appropriately with clear parameters, effectiveness reassessed and documented, hospice/provider notified when uncontrolled, new orders implemented properly, baseline care plans included pain management instructions, and communication documented (resident/RP/family/hospice) The in-service included a post-test to demonstrate understanding of topics and 19 nurses were present during the in-service and passed the post test before their shift was worked.Record reviews and observations of 7 residents , Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8 who received pain medications, revealed no signs or complaints of pain. The EHR revealed pain assessments and care plans were completed, and orders updated accordingly. Record review further revealed morphine orders were updated to ensure no medication ranges without parameters. Record review of the facility's audit tool on pain management and hospice coordination revealed the audit was completed on 12 residents to ensure a pain assessment was completed/identified, medication and parameters were updated, medications administration and reassessment, hospice provider coordination/escalation, decision-maker verifi[ |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455731 | A. Building<br>B. Wing | 01/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Advanced Health & Rehab Center of Garland | 1201 Colonel Drive<br>Garland, TX 75043 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 of 4 residents (Resident #2) reviewed for pharmaceutical services. MA T failed to supervise Resident #2 after she left the resident's medications in his room during morning medication administration on 01/04/26. This failure could place the residents at risk of not receiving medications as ordered by the physician. Findings included: Record review of Resident #2's Face Sheet, dated 01/04/26, reflected the resident was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Record review of the Resident #2's Quarterly MDS Assessment, dated 11/11/25, reflected the resident had diagnoses of Chronic Obstructive Pulmonary Disease (Progressive lung condition coughing airflow blockage), Chronic Respiratory Failure with Hypercapnia (Respiratory issues cause by too much carbon dioxide in the blood), Muscle Weakness, Heart Failure (heart is unable to effectively pump blood as it should), and Hypertension (high blood pressure). The MDS also reflected a BIMS score of 7, indicating he had moderate cognitive impairment. Record review of Resident #2's Care Plan, undated, reflected the resident had impaired visual function, an ADL self-care performance deficit and required assistance with feeding, required a mechanical soft diet with thin liquids with an intervention for staff to monitor for any swallowing difficulties/choking, and Resident #2 used antidepressant/anxiety medications. Record review of Resident #2's Assessment Notes on 01/04/26 reflected no assessment for self-administration of medications and competency to manage their own medications were completed. Record review of Resident #2's Physician Orders reflected the following orders scheduled for the morning: Amlodipine Besylate Tablet 10 MG Give 1 tablet by mouth one time a day related to Essential (Primary) Hypertension hold med if SBP is less than 100 and DBP was less than 60, Pulse < 60. Carvedilol Oral Tablet 6.25 MG Give 0.5 tablet by mouth two times a day related to Essential (Primary) Hypertension (I10) Hold if SBP < 100 and DBP < 60 and PULSE < 60. Give with food. Hydralazine HCl Oral Tablet 25 MG Give 1 tablet by mouth every 8 hours related to Essential (Primary) Hypertension hold medication if SBP is less than 100 and DBP was less than 60 and pulse < 60. Protonix Oral Tablet Delayed Release 40 MG (Pantoprazole Sodium) Give 1 tablet by mouth two times a day for GERD. Sennosides-Docusate Sodium Tablet 8.6-50 MG Give 1 tablet by mouth two times a day for Constipation, hold for loose stools. Vitamin C Oral Tablet 250 MG Give 1 tablet by mouth in the morning related to Anemia In Chronic Kidney Disease. Lisinopril Oral Tablet 40 MG Give 1 tablet by mouth in the morning related to Essential (Primary) Hypertension hold med if SBP was less than 100 and DBP was less than 60 and pulse < 60. Famotidine Tablet 20 MG Give 1 tablet by mouth two times a day for acid indigestion in the morning every Sat for vitamins. Ferrous Sulfate Oral Tablet 325 mg Give 1 tablet by mouth three times a day for anemia.Record review of Resident #2's January 2026 MAR reflected on 01/04/26 she was given Vitamin C, Famotidine (medication for stomach acid indigestion), Protonix (reduces stomach acid), Ferrous sulfate (for iron deficiency), Sennosides-docusate sodium (constipation medication). The MAR also reflected that all blood pressure medications were not given due to vital signs being out of range. Observation and interview on 01/04/26 at 9:55 AM revealed MA T mixed crushed medications with pudding. MA T brought the medication cup into Resident #2's room and placed it on the resident's bedside table. MA T notified Resident #2 that his medications were there, and she left the room. At 9:56 AM, the medication cup with the crushed medications in the pudding was observed on the resident's bedside table. Resident #2 stated he was going to take the medications.Observation and interview on 01/04/26 at 10:57 AM with Resident #2<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revealed the medicine cup was no longer on the bedside table. Resident #2 stated the staff only left his medications on the table when he told them he was busy. He stated if he was not busy, he took them right away. Resident #2 stated the staff did not watch him take his medications that day, but he did take them. Interview on 01/04/26 at 2:05 PM with MA T revealed she left the medications in front of Resident #2. MA T stated Resident #2 told her to leave them; so she did. MA T stated she did not see him take the medications, but she went back to check and he had. MA T stated she could not recall exactly what medications she gave, but Resident #2's blood pressure medications were held due to the parameters. MA T stated she was not supposed to leave the medications in the room, but Resident #2 was alert, and she was close by. MA T stated the risk of leaving medications unattended was that other residents could take the medications. Interview on 01/05/26 at 11:30 AM with ADON M revealed she expected her staff to pass medications timely and complete the 5 rights of administration (Right patient, right medication, right dose, right time, and right route). She stated she also expected her staff to stay with the residents until all the medications were swallowed. ADON M stated it was unacceptable to leave any medications unattended at the bedside. ADON M stated there were no residents that self-administered medications in the facility. ADON M stated the risk of leaving medications unattended was that the residents could choke, not take the medications, another resident could take them, or an allergic reaction could occur. Interview on 01/05/26 at 12:38 PM with ADON N revealed he expected the staff to follow the medication policy and complete the rights of medication administration. ADON N stated staff should never leave medications unattended in the residents' rooms. ADON N stated leaving medications was a big problem because the resident could overdose or other residents had access to it. Interview on 01/05/26 at 12:50 PM with the DON revealed she expected the staff to follow the guidelines for medication pass. The DON also stated all the medication rights should be followed. The DON stated there were no residents that could self-administer in the facility. The DON stated it was never acceptable for staff to leave medications in the rooms unattended. The DON stated the resident could throw the medications away, another resident could take them, or the resident could choke. The DON stated she was not aware of any medications left unattended and would start in-servicing staff to prevent this from recurring. Interview on 01/05/26 at 3:47 PM with the Administrator revealed she expected her staff to follow physician orders with medication pass, and to watch the residents take the medications to ensure the residents received the dose. The Administrator stated the risk of leaving medications unattended was that the resident could miss a dose of medications. The Administrator stated she would coordinate with the DON to in-service and educate about not leaving medications with the resident. Record review of the facility's Medication Administration: Medication Pass policy, reviewed 02/10/20, reflected the following: .9. Administer medication. Knock on door and request entrance, Introduce self, explain medication administration need and provide privacy, administer medication in accordance with frequency prescribed by physician. Take medication(s) and cup of liquid/food, if applicable, to patientIdentify patient by: calling name, checking Identification Band, referring to photoDescribe name of medication and reason for use to patient and answer any questions as neededAdminister medication according to specific procedure such as oral, topical or injectableRemain with patient until administration of medications is completeDocument initials on MAR for each medication administered. |