STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455817	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on observations, interviews, and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation was made to the State Survey Agency for 1 (Resident #1) of 13 residents reviewed for abuse and neglect. The facility did not report to the State Survey Agency (HHSC) an incident in which Resident #1 attempted suicide. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included: Record review of Resident #1's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), depression, and anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder. Resident #1 was noted as discharged on [DATE] to an acute care hospital. Record review of Resident #1's State Optional MDS, dated [DATE], revealed the resident had a BIMS score of 8, which indicated the resident was mildly cognitively impaired for daily decision-making skills. Record review of Resident #1's MDS PHQ9 (Resident Mood Interview), dated 03/12/2024, revealed Resident #1 with score of 18, he had moderately severe depression. The SW wrote under explanation, He said that he is hearing voices and forgetting things that he does not want to live. He is open to getting psych services. Record review of Resident #1's care plan revealed: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER San Antonio North Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Ogden San Antonio, TX 78212	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A focus, initiated on 03/13/2024, revealed Resident #1 had impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions with intervention, date initiated 03/13/2024, Monitor/document/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. - A focus, initiated on 03/19/2024, revealed Resident #1 had a potential psychosocial well-being problem related to depression, anxiety, inability to problem solve, ineffective coping, and lack of acceptance to current condition with intervention, date initiated 03/19/2024, Consult with: Pastoral care, Social services, Psych services. Record review of Resident #1's progress note, dated 05/02/2024 and authored by LVN A, revealed Incident of apparent suicide attempt. Resident #1 attempted suicide on 05/02/2024 by tying a shirt, fashioned to look like a rope, around his neck in a noose fashion, and pulling hard on the shirt to make it tighten enough to cut off his airflow. Record review of Resident #1's progress note, dated 05/02/2024 and authored by the ADMIN, revealed Resident #1 was admitted and stable at a local hospital. Attempted interview of LVN A on 05/22/2024 at 10:01 a.m., on 05/23/2024 at 08:07 a.m., and on 05/25/2024 at 10:59 p.m. and 11:03 p.m. was unsuccessful. LVN A worked night shift (10 p.m. to 6 a.m.). In an interview with Director of Case Management at local hospital on 05/24/2024 at 05:40 p.m., the Director of Case Management at local hospital stated Resident #1 was admitted to the hospital for suicide attempt. She stated that Resident #1 had confirmed that he attempted suicide. In an interview with the ADMIN on 05/28/2024 at 06:26 p.m., the ADMIN stated she had reviewed the pathway to determine if an attempted suicide was reportable and didn't see it qualifying as a reportable incident. The ADMIN stated she had discussed the incident with the RDCS, but it was her decision to not report. The ADMIN stated she followed the facility's prior procedures for attempted suicides, which occurred prior to her employment at the facility, and if there were future incidents, she and the management staff would still follow the pathways and determine if the management team missed anything in regard to reporting incidents. Record review of the facility's policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not limited to: .j. any other individual .8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. Record review of the facility's policy, Recognizing Signs and Symptoms of Abuse/Neglect, revised April 2021, revealed 4. The following are signs and symptoms of abuse/neglect that should be promptly reported . d. Psychological or behavioral signs of abuse or neglect .(10) Suicidal ideation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the HHSC Long-Term Care Regulatory Provider Letter, Number PL 19-17, date issued 7/10/19 and titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC), revealed in part, .This letter provides guidance for reporting incidents to HHSC .A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Abuse, Neglect, .The following table describes required reporting timeframes for each incident type .abuse (with or without serious bodily injury) .Immediately, but not later than two hours after the incident occurs or is suspected .Attachment 1: Definitions and Examples of ANE and other Reportable Incidents .Abuse: HHSC rules define abuse as: 'The negligent or willful infliction of injury .with resulting physical or emotional harm or pain to a resident .' . CMS defines abuse as: 'The willful infliction of injury .instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish .'.

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NAME OF PROVIDER OR SUPPLIER San Antonio North Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Ogden San Antonio, TX 78212	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on interviews and record reviews, the facility failed to thoroughly investigate allegations of abuse and neglect for 1 (Resident #1) of 13 residents reviewed. The facility did not have evidence that a thorough investigation was completed for Resident #1 who had attempted suicide. This failure could place residents at risk of incidents not being thoroughly investigated. The findings included: Record review of Resident'#1's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), depression, and anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder. Resident #1 was noted as discharged on [DATE] to an acute care hospital. Record review of Resident #1's State Optional MDS, dated [DATE], revealed the resident had a BIMS score of 8, which indicated the resident was mildly cognitively impaired for daily decision-making skills. Record review of Resident #1's MDS PHQ9 (Resident Mood Interview), dated 03/12/2024 revealed Resident #1 with score of 18, he had moderately severe depression. The SW wrote under explanation He said that he is hearing voices and forgetting things that he does not want to live. He is open to getting psych services. Record review of Resident #1's care plan revealed: - A focus, initiated on 03/13/2024, revealed Resident #1 had impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions with intervention, date initiated 03/13/2024, Monitor/document/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. - A focus, initiated on 03/19/2024, revealed Resident #1 had a potential psychosocial well-being problem related to depression, anxiety, inability to problem solve, ineffective coping, and lack of acceptance to current condition with intervention, date initiated 03/19/2024, Consult with: Pastoral care, Social services, Psych services. Record review of Resident #1's progress note, dated 05/02/2024 and authored by LVN A, revealed Incident of apparent suicide attempt. Resident #1 attempted suicide on 05/02/2024 by tying a shirt, fashioned to look like a rope, around his neck in a noose fashion, and pulling hard on the shirt to make it tighten enough to cut off his airflow. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress note, dated 05/02/2024 and authored by the ADMIN, revealed Resident #1 was admitted and stable at a local hospital. Record review of the facility report Incidents by Incident Type, dated 02/01/2024 to 05/17/2024, revealed no evidence of an incident on 05/02/2024 involving Resident #1. Record review of Resident #1's documentation in the facility EHR revealed no evidence of an investigation of an incident on 05/02/2024 involving Resident #1. In an interview with the ADMIN on 05/22/2024 between 9:00 a.m. - 10:00 a.m., the ADMIN stated Resident #1's incident on 05/02/2024 had been reported to her by the reporting nurse (LVN A); however, his report was inconsistent with the charge nurse, RN F. The ADMIN revealed the incident was not further investigated or reported because the incident was believed to have been incorrectly documented as an attempted suicide. Attempted interview of LVN A on 05/22/2024 at 10:01 p.m., on 05/23/2024 at 08:07 a.m., and on 05/25/2024 at 10:59 p.m., and 11:03 p.m. was unsuccessful. LVN A worked night shift (10 p.m. to 6 a.m.). In an interview with RN F on 05/23/2024 at 02:39 p.m., RN F stated he was working on the first floor of the facility on the night of Resident #1's attempted suicide. When he was called upstairs for the incident, he did not see any physical signs expected on Resident #1 from someone that tried to hurt themselves. RN F stated Resident #1 did not have a mark on his body, had no redness around his neck, did not appear in distress, and was lying perfectly in bed. RN F stated he took Resident #1's vitals, which were okay. In an interview with Director of Case Management at local hospital on 05/24/2024 at 05:40 p.m., the Director of Case Management at local hospital stated Resident #1 was admitted to the hospital for suicide attempt. She stated that Resident #1 had confirmed that he attempted suicide. Attempted record request on 05/24/2024 at 09:11 a.m. for local hospital admission records for Resident #1. Records not received prior to investigation exit. In an interview with the ADMIN on 05/28/2024 at 06:26 p.m., the ADMIN stated she had discussed Resident #1's incident on 05/02/2024 with the RDCS but it was her decision to not report. The ADMIN stated she followed the facility's prior procedures for attempted suicides, which occurred prior to her employment at the facility, and if there were future incidents, she and the management staff would still follow the pathways and determined if the management team missed anything in regard to reporting incidents. Record review of the facility's policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not limited to: .j. any other individual .8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Recognizing Signs and Symptoms of Abuse/Neglect, revised April 2021, revealed 4. The following are signs and symptoms of abuse/neglect that should be promptly reported . d. Psychological or behavioral signs of abuse or neglect .(10) Suicidal ideation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER: San Antonio North Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 Ogden San Antonio, TX 78212	

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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 0656

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46447

Based on interview and record review, the facility failed to implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 (Resident #1) of 13 residents reviewed for comprehensive care plan, in that:

LVN A failed to follow the plan of care on 05/01/2024 which required Resident #1 to be monitored and a PCP to be notified if Resident demonstrated a fear of being alone. Resident #1 attempted suicide on 05/02/2024.

This failure resulted in the identification of Immediate Jeopardy (IJ) on 05/26/2024 at 06:00 p.m. While the IJ was removed on 05/28/2024, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility's need to monitor the implementation of the plan of removal.

This failure could result in residents not receiving the necessary care to prevent a decline in health due to failure to follow a resident's care plan.

Findings included:

Record review of Resident #1's Admission Record, dated 05/24/2024 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), depression, and anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder. Resident #1 was noted as discharged on [DATE] to an acute care hospital.

Record review of Resident #1's State Optional MDS, dated [DATE], revealed the resident had a BIMS score of 8, which indicated the resident was mildly cognitively impaired for daily decision-making skills.

Record review of Resident #1's MDS PHQ9 (Resident Mood Interview), dated 03/12/2024, revealed the resident had a score of 18, which indicated the resident had moderate severe depression. Further review revealed the SW wrote under explanation, He said that he is hearing voices and forgetting things that he does not want to live. He is open to getting psych services.

Record review of Resident #1's care plan revealed:

- A focus, initiated on 03/13/2024, revealed Resident #1 had impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions with intervention, date initiated 03/13/2024, Monitor/document/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- A focus, initiated on 03/15/2024 and revised on 04/30/2024, revealed Resident #1 used anti-histamine medications related to anxiety/agitation with interventions, date initiated 03/15/2024, [Resident #1] is taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia .Monitor for safety and Monitor/record occurrence of for target behavior symptoms and document per facility protocol. - A focus, initiated on 03/19/2024, revealed Resident #1 used antidepressant medication related to depression with interventions, date initiated 03/19/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: sad, .suicidal ideations, .fear of being alone or with others .anxiety . - A focus, initiated on 03/19/2024, revealed Resident #1 had a potential psychosocial well-being problem related to depression, anxiety, inability to problem solve, ineffective coping, and lack of acceptance to current condition with intervention, date initiated 03/19/2024, Consult with: Pastoral care, Social services, Psych services. Record review of Resident #1's MAR/TAR for April and May 2024 did not reveal behavior was being monitored according to the care plan. Record review of Resident #1's Psychiatry Follow-Up note, dated 04/29/2024 revealed a note by Psych NP that stated He was recently in an altercation and he was not the aggressor .No increased depression. He is sleeping and eating well. He is nervous about the aggressors hurting him again. He is having some anxiety regarding the situation. Further review revealed Resident #1 was noted as not currently a danger to self/others, not a risk factor for self-harm, and not a risk factor for suicidal ideation. Under assessment and plan, increased anxiety due to altercation was noted. Record review of Resident #1's progress note, dated 05/01/2024 did not reveal an entry by LVN A and did not reveal a notation regarding Resident #1 displaying increased fear or a request for a staff member to stay with him. Record review of Resident #1's progress note, dated 05/02/2024 revealed a note by LVN A that stated he asked me the previous evening to stay in the room with him because he was scared. He did not clarify what he was scared of, only that he was afraid and wanted me to stay with. The note revealed Further review revealed Resident #1 attempted suicide on 05/02/2024 by tying a shirt, fashioned to look like a rope, around his neck in a noose fashion and pulling hard on the shirt to make it tighten enough to cut off his airflow. Attempted interview of LVN A on 05/22/2024 at 10:01 p.m., on 05/23/2024 at 08:07 a.m., and on 05/25/2024 at 10:59 p.m. and 11:03 p.m. was unsuccessful. LVN A worked night shift (10:00 p.m. to 6:00 a.m.). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024

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San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Psych NP on 05/23/2024 at 04:33 p.m., revealed the Psych NP stated she had assessed Resident #1 on 04/29/2024 and found that he had been okay. The Psych NP stated Resident #1 had initially been very anxious and impulse upon admission to the facility but with medication therapy he had been fine and no longer had depression. The Psych NP stated she thought Resident #1 was anxious after the altercation on 04/28/2024 and he did not want to be alone with anyone with aggression. The Psych NP stated Resident #1 did not have any indication of being at risk for self-harm. The Psych NP stated she never observed, and no one ever reported to her that Resident #1 was at risk for self-harm or suicidal. The Psych NP stated that the facility had standard orders for behavioral monitoring for residents on psychotropics. The Psych NP stated the facility staff was really good at notifying her of any issues when she was in the facility, at least weekly, or calling her. The Psych NP stated the nurses could contact the psych care team twenty-four hours, seven days a week by calling the call center. Interview with MD E on 05/25/2024 at 12:52 p.m., MD E stated she had received notification by a facility nurse on 05/02/2024 that Resident #1 had been sent out to the hospital. MD E stated she had not seen Resident #1 but that he was being seen by the Psych NP, who last saw the resident on 04/29/2024. MD E stated the facility nurses reported incidents or changes of conditions to the medical team's call center. MD E stated the reported information would disseminate to the entire care team, including the psychiatric services team. MD E stated she deferred to the psychiatric services team for behavioral issues or concerns. MD E stated the facility nurses' process of charting in the facility EHR and reporting to the care team or medical call center any changes was adequate for behavioral monitoring. Interview with LVN B on 05/26/2024 at 04:15 p.m., LVN B stated she reviewed resident care plans when she had a question about the resident's care but would only review the specific parts of care plan that she needed information on. Interview with ADON C on 05/26/2024 at 04:58 p.m., ADON C stated her expectation was that direct care staff were to follow the care plan. Interview with MD E on 05/28/2024 at 12:33 p.m., MD E stated she did not recall being notified of Resident #1 ever saying that he did not want to live, per his 03/12/2024 PHQ9 Assessment, or received a report the resident was afraid on the night of 05/01/2024. MD E stated she would have to check her notes. A return call was not received by [Investigator I] prior to the investigation exit, 05/28/2024 at 06:00 p.m. Interview with the Psych NP on 05/28/2024 at 01:44 p.m., the Psych NP stated she did not recall Resident #1 ever saying that he did not want to live. The Psych NP stated Resident #1 was referred to psych services on 03/14/2024 by a facility nurse and could not recall a staff member reporting to her that during his PHQ9 Assessment, Resident #1 said he did not want to live. The Psych NP stated she had a hard time seeing Resident #1 making that statement and stated that she felt the screening assessments could sometimes lead to a response or misunderstanding due to the wording of the questions. The Psych NP stated she did not feel that people with dementia could complete those screeners appropriately. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER San Antonio North Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Ogden San Antonio, TX 78212	

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed. A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including .(3) which professional services are responsible for each element of care; . This was determined to be an Immediate Jeopardy (IJ) and the ADMIN was provided with the IJ template on 05/26/2024 at 6:00 p.m. The plan of removal was accepted on 05/27/2024 at 1:18 p.m. and read as follows: Summary of details which leads to outcomes. On 5/17/24 an investigation on a facility reported incident was initiated at [the facility]. On 5/26/2023 at 6:00pm, [Investigator I] provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The Immediate Jeopardy findings were identified in the following areas: F656: The facility failed to implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for Resident #1. Immediate Corrective Actions for Removal of Immediate Jeopardy: On May 25, 2024, at approximately 12:00 [p.m.] the following actions were initiated upon facility identification of concern: - Ad hoc QAPI meeting held with Administrator, Regional Director of Clinical Operations, ADONs and MD to review process for psychosocial management to include monitoring orders for side effects and effectiveness of medications, and psychosocial assessments. - All resident charts were audited to ensure that care plans include measurable objective and timeframes to meet a resident's medical, nursing, mental and psychosocial needs. - All residents who are currently prescribed psychotropic medication were audited to ensure side effect monitoring and effectiveness of medication monitoring were in place and care planned. - All residents who did not currently have side effects and medication effectiveness monitoring were assessed for adverse effects to psychosocial wellbeing related to monitoring orders not being in place. All residents remained at base line with no adverse effects noted. - Education was initiated immediately with licensed nursing staff, on side effect monitoring and medication effectiveness and reporting psychosocial changes to provider with a completion date of 05/26/2024. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Education initiated to nursing staff on comprehensive care planning and identification of psychosocial interventions with a completion date of 05/26/2024 Identification of Other Affected: All residents who are diagnosed with a mental disorder or psychosocial adjustment have the potential to be affected. Systemic Changes and/or Measures: - Education provided to all nursing staff on May 26, 2024, on Behavioral monitoring, including the requirement to monitor resident for altered mood, behavior, and function and alert the physician via phone with any observations noted, with a completion date of 05/27/2024. - Education provided to all nursing staff on May 26, 2024, on Comprehensive, person-centered care planning, and requirement that nursing staff is aware of residents' plan of care when providing resident care. Education also included that care plans include measurable, person-centered, objectives and timetables to assure residents highest functional, and psychosocial well-being are attained, with a completion date of 05/24/2024. - Ad hoc QAPI meeting held with IDT team and MD to review findings of immediate jeopardy, and to review Plan of Removal/response to Immediate Jeopardy Citation on 5/26/24 @ 8:00 p.m. Tracking and Monitoring: - Assistant Director of Nursing, or designee, will monitor daily through daily clinical meeting and review, Monday through Friday, all new admissions, and new orders, for any psychotropic medications, to validate all residents on psychotropics, have behavior monitoring, monitoring for adverse side effects, and care plan is person-centered and addresses specific behaviors being monitored. Any identified concerns will be addressed immediately, and physician will be notified via phone with any observations noted. - Assistant Director of Nursing, or designee, will review 24 hours report in EHR, to identify any new, acute, mental, or psychosocial concerns from previous day, to validate they were addressed and follow up with provider/physician was completed as indicated. Physician will be notified via phone with any observations noted. The 24 hours report shall include indication of monitoring orders in place and verification of observations noted. Any identified concerns will be addressed immediately. The facility's POR verification was as follows: Interview with the ADMIN on 05/27/2024 at 03:00 p.m., the ADON stated all the nursing staff had received education on behavioral monitoring and care plans. The Administrator stated that the facility had a QAPI meeting on 05/26/2024 and discussed the findings of the deficient practice and the plan of removal. The Administrator stated MD E was the facility medical director. Record review of facility POR Binder on 05/27/2024 at 03:00 p.m. revealed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: San Antonio North Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 Ogden San Antonio, TX 78212	

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. A copy of the two Ad hoc QAPI Meetings: - The first Ad hoc QAPI document was dated 05/24/2024 and noted with an agenda: Psychotropic Medications, Monitoring and Observations Orders, Auditing, and Psych. Services auditing. Attendees were noted as: the ADMIN, MD E, ADON C, ADON D, and the RDCS. - The second Ad Hoc QAPI document was dated 05/26/2024 and noted with agenda: Immediate Jeopardy Citations- F656, F742, and Plan of Removal. Attendees were noted as: the ADMIN, MD E, ADON C, ADON D, and the RDCS. The binder contained a list of 19 licensed nursing staff. 2. An In-service document, dated 05/26/2024 and titled All nurses must monitor residents for psych issues such as withdrawn behaviors, signs/symptoms or verbalization of fear, depression, anxiety, anger/aggressive behavior, self-harm or attempted self-harm, suicidal ideation or statements and must else report it to nurse managers, administrator, doctor/nurse practitioner, and responsible party. The in-service document included a note *orders for monitoring psych diagnosis and psych meds must be added on admission or new orders. MD must be notified if behaviors observed and included 19 (9 LVN and 10 RN) licensed nurses noted as had received the training. 3. A document titled F656 Develop/Implement Comprehensive Care Plans revealed care plans were audited on 05/26/2025, the corrected care plans were noted on the order listing report, and the reviewer was the ADON and MDS staff. The document noted the care plans were audited on 05/27/2024 and found to be up to date by the ADON and MDS staff. A facility report, Daily Census, dated 05/26/2024 was included with the audit document with each resident name checked off. 4. A document titled F742 Treatment/Services for Mental/Psychosocial Concerns revealed psychosocial monitoring orders were audited on 05/25/2025, 05/26/2024, and 05/27/2024. For 05/25/2024 and 05/26/2024, the audit form indicated the need for psychosocial assessments. A facility report, Order Listing Report, dated 05/24/2024 - 05/25/2024 was included with the audit document with 36 resident names highlighted and checked off and 14 residents were noted as having a current monitoring order. Interviews with 17 of 19 licensed nursing staff from different shifts was completed on 05/27/2024 and 05/28/2024 which consisted of 2 of 3 licensed nursing staff from morning shift (6:00 a.m. to 2:00 p.m.), 5 of 5 licensed nursing staff from afternoon shift (2:00 p.m. to 10:00 p.m.), 1 of 2 licensed nursing staff from night shift (10:00 p.m. to 6:00 a.m.), 4 of 4 PRN licensed nursing staff, 2 of 2 weekend licensed nursing staff, and 3 of 3 administrative (MDS, ADON C, ADON D) licensed nursing staff. All 17 staff members reported they received education and were trained on behavioral monitoring, notifying the physician of behaviors, and reviewing and updating the residents' care plan. Attempted interview of RN G on 05/27/2024 at 06:19 p.m. and LVN A on 05/27/2024 at 7:11 p.m. to confirm training was unsuccessful. RN G worked morning shift (6:00 a.m. to 2:00 p.m.) and LVN A worked night shift (10:00 p.m. to 6:00 a.m.). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with ADON D on 05/28/2024 at 10:48 a.m., ADON D stated she received training from the RDCS regarding behavioral monitoring and care planning, and she provided the training to ADON C and facility licensed nursing staff. ADON D stated the ADONs will be monitoring the psychosocial medications by reviewing the facility 24-hour, 72-hour, and Order Listing reports to identify if there were any new psychosocial mediations, reported behaviors, new treatment orders, new antibiotic medications, new monitoring orders, and any reported behaviors. The report on incidents would also be reviewed. ADON D stated the reports would be reviewed in the morning clinical meeting with the floor nurses and ADON C, to discuss if any changes or incidents occurred the prior day and/or over the weekend. ADON D revealed that by reviewing the Order Listing report and 24-hour or 72-hour report, the ADONs were able to audit that if a new medication order was entered, a progress note for that new medication was entered and verify that additional orders for monitoring the side effects, behaviors, and efficacy were entered. ADON D stated that by reviewing the Order Listing report and 24-hour or 72-hour report, the ADONs were able to review that when a PRN psychosocial medication was provided, a monitor for the behavior and efficacy was entered, and if needed, a progress note indicating that the physician was notified and description of the behavior or reason for providing the PRN medication was documented. ADON D stated that after the IJs were called, each residents' chart was audited for monitoring orders. ADON D stated that for some residents' charts, behavior monitoring, or side effect monitoring was found but not both, and for those residents the other monitor was added. ADON D revealed that the Psych NP was asked to also complete an audit, checking her records and notes to verify that all the monitoring orders were in. She revealed for the care plan audit, she and the MDS nurse reviewed the care plans for every resident and ensured that the interventions in the care plans were also in the orders. ADON D stated they only identified Resident #1 as having the type of monitoring language for sadness and fear of being alone in his care plan. ADON D stated that it was discussed with the Psych NP on how the facility would going forward word their monitor and interventions to reflect the facility's resident's needs and behaviors more accurately. Interview with the RDCS on 05/28/2024 at 06:08 p.m., the RDCS stated she had attended Ad hoc QAPI Meetings on 05/25/2024 and 05/26/2024. The RDCS stated she provided training to ADON D on behavioral monitoring and care planning so ADON D could train the licensed nursing staff. Interview with the MD E on 05/28/2024 at 12:36 p.m., MD E stated she had attended Ad hoc QAPI Meetings on 05/25/2024 and 05/26/2024. MD E stated she was informed of the IJ and the plans for removal. Interview with the Psych NP on 05/28/2024 at 01:44 p.m., the Psych NP stated she was notified of the IJ at the facility and was contacted by her supervisor regarding a request that she provide follow up assessments on specific residents to review current behaviors and monitoring orders. Interview with the ADMIN and record review of facility report Order Summary Report on 05/28/2024 at 04:50 p.m. revealed the facility staff did not create a tracking log of resident orders that were entered as a part of their plan of correction but stated the Order Summary Report start date 05/25/2024 with active orders as of 05/25/2024 captured the new orders created per the order audit. The report noted five (5) residents (Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) with new orders ordered on 05/24/2024 or 05/25/2024 with start dates 05/25/2024. New orders included observation for anti-depressant medication, observation for anti-anxiety medication, monitor for depression, monitor for anxiety, and monitor for side effects of sedative/hypnotics. The ADMIN revealed a new psychosocial assessment was completed on the five (5) identified residents. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Record review of Resident #2's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), depression, and post-traumatic stress disorder (a condition characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). Record review of Resident #2's State Optional MDS, dated [DATE], revealed Resident #2 had a BIMS score of 99, which indicated the resident was severely cognitively impaired for daily decision-making skills and/or unable to complete the interview. Record review of Resident #2's MDS PHQ9 (Resident Mood Interview), dated 04/11/2024, revealed Resident #2 had a score of NA. Record review of Resident #2's care plan revealed: - A focus, initiated on 04/15/2024, revealed Resident #2 used antidepressant medication related to depression with interventions, date initiated 04/15/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: sad, .suicidal ideations, .fear of being alone or with others .anxiety . - A focus, initiated on 04/15/2024, revealed Resident #2 had impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions, impaired decision making, long term memory loss, psychotropic drug use, short term memory loss with interventions, date initiated 04/15/2024, Administer meds as ordered and Review medications and record possible causes of cognitive deficit .adverse drug reactions, drug toxicity. - A focus, initiated on 04/17/2024 and revised on 04/23/2024, revealed Resident #2 used anti-anxiety medications and anti-convulsant medications related to anxiety disorder with interventions, date initiated 04/17/2024, [Resident #2] is taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia .Monitor for safety, Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness .Paradoxical side effects: mania, hostility and rage, aggressive or impulsive behavior, hallucinations, and Monitor/record occurrence of for target behavior symptoms and document per facility protocol. -A focus, initiated 04/15/2024, revealed Resident #2 had potential mood problems related to PTSD and dementia with intervention, date initiated 04/15/2024, Monitor/record/report to MD prn acute episode feelings or sadness . Record review of facility report Order Summary Report, start date on 05/25/2024 and active orders as of 05/25/2024, revealed two (2) orders for Resident #2, ordered on 05/24/2024 to start on 05/25/2024. The first order was: Observation: AntiDepressant Medication- Observe for behavior WITHDRAWN/ AGITATION. Observe for side effects .every shift. The second order was: Observation: Antianxiety Medication- Observe for behavior AGITATION. Observe for side effects .every shift. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Psychosocial Assessment, dated 05/25/2024, revealed Resident #2 was unable to participate in assessment due to severe cognitive impairment directly related to admitting diagnosis of dementia. Resident remained at baseline. No adverse psychosocial effects noted. Plan of Care revealed continue with current care plan and psych services involvement. Provide quiet space if resident appears to become overstimulated. Monitor for adverse effects to psychosocial well being. 2. Record review of Resident #3's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder, depression, and mild cognitive impairment (difficulty with language, memory, and thinking). Record review of Resident #3's State Optional MDS, dated [DATE], revealed Resident #3 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision-making skills. Record review of Resident #3's MDS PHQ9 (Resident Mood Interview), dated 01/03/2024, revealed Resident #3 had a score of 4, which indicated the resident was minimally depressed. Record review of Resident #3's care plan revealed: - A focus, initiated on 11/13/2023 and revised 05/07/2024, revealed Resident #3 had impaired cognitive function/ impaired thought processes related to difficulty making decisions, impaired decision making, mild cognitive impairment caused by history of alcoholic intoxication with interventions, date initiated 11/13/2023, Administer meds as ordered, Monitor/document/report to MD any changes in cognitive function ., and Review medications and record possible causes of cognitive deficit: .adverse drug reactions, drug toxicity. -A focus, initiated on 11/16/2023, revealed Resident #3 had potential psychosocial well-being problem related to illness/disease Process, disease process with intervention, date initiated 11/16/2023, Consult with . Psych services, Other. - A focus, initiated on 12/11/2023, revealed Resident #3 used antidepressant medication related to depression with interventions, date initiated 12/11/2023, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: sad, .suicidal ideations, .fear of being alone or with others .anxiety . Record review of facility report Order Summary Report, start date on 05/25/2024 and active orders as of 05/25/2024, revealed two (2) orders for Resident #3, ordered on 05/24/2024 to start on 05/25/2024. The first order was: Depression: Monitor for depressive symptomology .every shift Enter progress note describing behaviors observed if applicable. The second order was: Observation: AntiDepressant Medication- Observe for side effects .every shift. Record review of Psychosocial Assessment, dated 05/25/2024, revealed Resident #3 remained at baseline for psychosocial well-being with no adverse effects noted. Plan of Care revealed continue with current care plan. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Record review of Resident #4's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), insomnia (trouble falling and/or staying asleep), major depressive disorder(a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder, and suicide attempt, noted as initial encounter and dated 02/28/2024. Record review of Resident #4's State Optional MDS, dated [DATE], revealed Resident #4 had a BIMS score of 1, which indicated the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #4's MDS PHQ9 (Resident Mood Interview), dated 04/08/2024, revealed Resident #4 had a score of 4, which indicated the resident was minimally depressed. Record review of Resident #4's care plan revealed: - A focus, initiated on 02/28/2024 and revised on 05/18/2024, Resident #4 needed pain management and monitoring related depression with intervention, date initiated 02/28/2024, Observe for potential medication side effects. - A focus, initiated on 02/29/2024, revealed Resident #4 had impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions, impaired decision making, psychotropic drug use, short term memory loss with interventions, date initiated 02/29/2024, Administer meds as ordered, Monitor/document/report to MD any changes in cognitive function ., and Review medications and record possible causes of cognitive deficit: .adverse drug reactions, drug toxicity. - A focus, initiated on 03/04/2024 and revised on 04/18/2024, revealed Resident #4 used anti-histamine medications related to adjustment issues and anxiety disorder with interventions, date initiated 03/04/2024, Give anti-anxiety medications ordered by physician. Monitor/documents side effects and effectiveness ., Monitor/record occurrence of for target behavior symptoms and document per facility protocol, and [Resident #4] is taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia .Monitor for safety. - A focus, initiated on 03/06/2024, revealed Resident #4 used antidepressant and antiseizure medication related to depression and poor adjustment to admission with interventions, date initiated 03/06/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: sad, . suicidal ideations, .fear of being alone or with others .anxiety . - A focus, initiated 03/13/2024, revealed Resident #4 was at risk for psychosocial well-being problems related to dependent behavior, lack of acceptance to current condition, recent admission, dementia, and depression with intervention, date initiated 03/13/2024, Consult with .Psych services. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- A focus, initiated 02/29/2024, revealed Resident #4 had potential mood problems related to dementia with behaviors and history or suicidal behaviors with interventions, date initiated 02/29/2024, Monitor/record/report to MD prn acute episode feelings or sadness ., Monitor/record/report to MD prn mood patters s/sx of depression, anxiety, sad mood as per facility behavior monitoring protocols, Monitor/record/report to MD prn risk for harm to self: suicidal plan, past attempt at suicide ., and Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation . Record review of facility

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F 0742

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46447

Based on interviews and record review the facility failed to ensure a resident who displayed or was diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for 1 (Resident #1) of 13 residents reviewed for psychosocial concerns.

LVN A failed to put interventions in place or promptly arrange for psychiatric services for Resident #1 after he displayed increased signs of fear on 05/01/2024. Resident #1 attempted suicide on 05/02/2024.

This failure resulted in the identification of Immediate Jeopardy (IJ) on 05/26/2024 at 06:00 p.m. While the IJ was removed on 05/28/2024, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility's need to monitor the implementation of the plan of removal.

This failure to ensure interventions were implemented or psychiatric services were promptly arranged can result in the individual not receiving the necessary care to prevent a decline in health.

Findings included:

Record review of Resident #1's Admission Record, dated 05/24/2024 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), depression, and anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder. Resident #1 was noted as discharged on [DATE] to an acute care hospital.

Record review of Resident #1's State Optional MDS, dated [DATE], revealed the resident had a BIMS score of 8, which indicated the resident was mildly cognitively impaired for daily decision-making skills.

Record review of Resident #1's MDS PHQ9 (Resident Mood Interview), dated 03/12/2024, revealed the resident had a score of 18, which indicated he had moderately severe depression. Further review revealed the SW wrote under explanation, He said that he is hearing voices and forgetting things that he does not want to live. He is open to getting psych services.

Record review of Resident #1's care plan revealed:

- A focus, initiated on 03/13/2024, revealed Resident #1 had impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions with intervention, date initiated 03/13/2024, Monitor/document/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- A focus, initiated on 03/15/2024 and revised on 04/30/2024, revealed Resident #1 used anti-histamine medications related to anxiety/agitation with interventions, date initiated 03/15/2024, [Resident #1] is taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia .Monitor for safety and Monitor/record occurrence of for target behavior symptoms and document per facility protocol. - A focus, initiated on 03/19/2024, revealed Resident #1 used antidepressant medication related to depression with interventions, date initiated 03/19/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: sad .suicidal ideations .fear of being alone or with others .anxiety . - A focus, initiated on 03/19/2024, revealed Resident #1 had a potential psychosocial well-being problem related to depression, anxiety, inability to problem solve, ineffective coping, and lack of acceptance to current condition with intervention, date initiated 03/19/2024, Consult with: Pastoral care, Social services, Psych services. Record review of Resident #1's MAR/TAR for April and May 2024 did not reveal behavior was being monitored according to the care plan. Record review of Resident #1's Psychiatry Follow-Up note, dated 04/29/2024 revealed a note by Psych NP that stated He was recently in an altercation, and he was not the aggressor .No increased depression. He is sleeping and eating well. He is nervous about the aggressors hurting him again. He is having some anxiety regarding the situation. Further review revealed Resident #1 was noted as not currently a danger to self/others, not a risk factor for self-harm, and not a risk factor for suicidal ideation. Under assessment and plan, increased anxiety due to altercation was noted. Record review of Resident #1's progress note, dated 05/01/2024 did not reveal an entry by LVN A and did not reveal a notation regarding Resident #1 displaying increased fear or a request for a staff member to stay with him. Record review of Resident #1's progress note, dated 05/02/2024 revealed a note by LVN A that stated he asked me the previous evening to stay in the room with him because he was scared. He did not clarify what he was scared of, only that he was afraid and wanted me to stay with. Further review revealed Resident #1 attempted suicide on 05/02/2024 by tying a shirt, fashioned to look like a rope, around his neck in a noose fashion, and pulling hard on the shirt to make it tighten enough to cut off his airflow. Attempted interview of LVN A on 05/22/2024 at 10:01 p.m., on 05/23/2024 at 08:07 a.m., and on 05/25/2024 at 10:59 p.m. and 11:03 p.m. was unsuccessful. LVN A worked night shift (10:00 p.m. to 6:00 a.m.). (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with Psych NP on 05/23/2024 at 04:33 p.m., revealed the Psych NP stated she had assessed Resident #1 on 04/29/2024 and found that he had been okay. The Psych NP stated Resident #1 had initially been very anxious and impulse upon admission to the facility but with medication therapy he had been fine and no longer had depression. The Psych NP stated she thought Resident #1 was anxious after the altercation on 04/28/2024 and he did not want to be alone with anyone with aggression. The Psych NP stated Resident #1 did not have any indication of being at risk for self-harm. The Psych NP stated she never observed, and no one ever reported to her that Resident #1 was at risk for self-harm or suicidal. The Psych NP stated that the facility had standard orders for behavioral monitoring for residents on psychotropics. The Psych NP stated the facility staff were really good at notifying her of any issues when she was in the facility, at least weekly, or calling her. The Psych NP stated the nurses could contact the psych care team twenty-four hours, seven days a week by calling the call center. In an interview with MD E on 05/25/2024 at 12:52 p.m., MD E stated she had received notification by a facility nurse on 05/02/2024 that Resident #1 had been sent out to the hospital. MD E stated she had not seen Resident #1 but that he was being seen by the Psych NP, who last saw the resident on 04/29/2024. MD E stated the facility nurses reported incidents or changes of conditions to the medical team's call center. MD E stated the reported information would disseminate to the entire care team, including the psychiatric services team. MD E stated she deferred to the psychiatric services team for behavioral issues or concerns. MD E stated the facility nurses' process of charting in the facility EHR and reporting to the care team or medical call center any changes was adequate for behavioral monitoring. In an interview with LVN B on 05/26/2024 at 04:15 p.m., LVN B stated she reviewed resident care plans when she had a question about the resident's care but would only review the specific parts of the care plan that she needed information on. In an interview with ADON C on 05/26/2024 at 04:58 p.m., ADON C stated her expectation was that direct care staff were to follow the care plan. In an interview with MD E on 05/28/2024 at 12:33 p.m., MD E stated she did not recall being notified of Resident #1 ever saying that he did not want to live, per his 03/12/2024 PHQ9 Assessment, or received a report the resident was afraid on the night of 05/01/2024. MD E stated she would have to check her notes. A return call was not received by [Investigator I] prior to the investigation exit, 05/28/2024 at 06:00 p.m. In an interview with the Psych NP on 05/28/2024 at 01:44 p.m., the Psych NP stated she did not recall Resident #1 ever saying that he did not want to live. The Psych NP stated Resident #1 was referred to psych services on 03/14/2024 by a facility nurse and could not recall a staff member reporting to her that during his PHQ9 Assessment, Resident #1 said he did not want to live. The Psych NP stated she had a hard time seeing Resident #1 making that statement and stated that she felt the screening assessments could sometimes lead to a response or misunderstanding due to the wording of the questions. The Psych NP stated she did not feel that people with dementia could complete those screeners appropriately. (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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident .7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including (3) which professional services are responsible for each element of care . This was determined to be an Immediate Jeopardy (IJ) and the ADMIN was provided with the IJ template on 05/26/2024 at 6:00 p.m. The plan of removal was accepted on 05/27/2024 at 1:18 p.m. and read as follows: Summary of details which lead to outcomes. On 5/17/24 an investigation on a facility reported incident was initiated at [the facility]. On 5/26/2023 at 6:00pm, [Investigator I] provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The Immediate Jeopardy findings were identified in the following areas: 0742: The facility failed to ensure a resident who displayed or was diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for Resident #1. Immediate Corrective Actions for Removal of Immediate Jeopardy: On May 25, 2024, at approximately 12:00 [p.m.] the following actions were initiated upon facility identification of concern: - Ad hoc QAPI meeting held with Administrator, Regional Director of Clinical Operations, ADONs and MD to review process for psychosocial management to include monitoring orders for side effects and effectiveness of medications, and psychosocial assessments. - All resident charts were audited to ensure that care plans include measurable objective and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs. - All residents who are currently prescribed psychotropic medication were audited to ensure side effect monitoring and effectiveness of medication monitoring were in place and care planned. - All residents who did not currently have side effects and medication effectiveness monitoring were assessed for adverse effects to psychosocial wellbeing related to monitoring orders not being in place. All residents remained at base line with no adverse effects noted. - Education was initiated immediately with licensed nursing staff, on side effect monitoring and medication effectiveness, and reporting psychosocial changes to provider with a completion date of 5/26/2024. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Education initiated to nursing staff on comprehensive care planning and identification of psychosocial interventions with a completion date of 5/26/2024. Identification of other affected: All residents who are diagnosed with a mental disorder or psychosocial adjustment have the potential to be affected. Systemic Changes and/or Measures: - Education provided to all nursing staff on May 26, 2024, on behavioral monitoring, including the requirement to monitor resident for altered mood, behavior, and function and alert the physician via phone with any observations noted with a completion date of 5/27/2024. - Education provided to all nursing staff on May 26, 2024, on Comprehensive, person-centered care planning, and requirement that nursing staff is aware of residents' plan of care when providing resident care. Education also included that care plans include measurable, person-centered, objectives, and timetables to assure residents highest functional, and psychosocial well-being are attained with a completion date of 5/27/2024. - Ad hoc QAPI meeting held with IDT team and MD to review findings of immediate jeopardy, and to review Plan of removal/response to Immediate Jeopardy Citation on 5/26/24 @ 8:00 pm Tracking and Monitoring: - Assistant Director of Nursing, or designee, will monitor daily through daily clinical meeting and review, Monday through Friday, all new admissions, and new orders, for any psychotropic medications, to validate all residents on psychotropics, have behavior monitoring, monitoring for adverse side effects, and care plan is person-centered and addresses specific behaviors being monitored. Any identified concerns will be addressed immediately and physician will be notified via phone with any observations noted. - Assistant Director of Nursing, or designee, will review 24 hours report in EHR, daily Monday through Friday, to identify any new, acute, mental, or psychosocial concerns from previous day, and validate they were addressed to include follow up with provider/physician was completed as indicated. The 24 hours report shall include indication of monitoring orders in place and verification of observations noted. Any identified concerns will be addressed immediately and physician will be notified via phone with any observations noted. The facility's POR Verification was as follows: Interview with the ADMIN on 05/27/2024 at 03:00 p.m., the ADON stated all the nursing staff had received education on behavioral monitoring and care plans. The Administrator stated that the facility had a QAPI meeting on 05/26/2024 and discussed the findings of the deficient practice and the plan of removal. The Administrator stated MD E was the facility medical director. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility POR Binder on 05/27/2024 at 03:00 p.m. revealed: 1. A copy of the two Ad hoc QAPI Meetings: - The first Ad hoc QAPI document was dated 05/24/2024 and noted with an agenda: Psychotropic Medications, Monitoring and Observations Orders, Auditing, and Psych. Services auditing. Attendees were noted as: the ADMIN, MD E, ADON C, ADON D, and the RDCS. - The second Ad Hoc QAPI document was dated 05/26/2024 and noted with agenda: Immediate Jeopardy Citations- F656, F742, and Plan of Removal. Attendees were noted as: the ADMIN, MD E, ADON C, ADON D, and the RDCS. The binder contained a list of 19 licensed nursing staff. 2. An In-service document, dated 05/26/2024 and titled All nurses must monitor residents for psych issues such as withdrawn behaviors, signs/symptoms or verbalization of fear, depression, anxiety, anger/aggressive behavior, self-harm or attempted self-harm, suicidal ideation or statements and must else report it to nurse managers, administrator, doctor/nurse practitioner, and responsible party. The in-service document included a note *orders for monitoring psych diagnosis and psych meds must be added on admission or new orders. MD must be notified if behaviors observed and included 19 (9 LVN and 10 RN) licensed nurses noted as had received the training. 3. A document titled F656 Develop/Implement Comprehensive Care Plans revealed care plans were audited on 05/26/2025, the corrected care plans were noted on the order listing report, and the reviewer was the ADON and MDS staff. The document noted the care plans were audited on 05/27/2024 and found to be up to date by the ADON and MDS staff. A facility report, Daily Census, dated 05/26/2024 was included with the audit document with each resident name checked off. 4. A document titled F742 Treatment/Services for Mental/Psychosocial Concerns revealed psychosocial monitoring orders were audited on 05/25/2025, 05/26/2024, and 05/27/2024. For 05/25/2024 and 05/26/2024, the audit form indicated the need for psychosocial assessments. A facility report, Order Listing Report, dated 05/24/2024 - 05/25/2024 was included with the audit document with 36 resident names highlighted and checked off and 14 residents were noted as having a current monitoring orders. Interviews with 17 of 19 licensed nursing staff from different shifts were completed on 05/27/2024 and 05/28/2024 which consisted of 2 of 3 licensed nursing staff from morning shift (6:00 a.m. to 2:00 p.m.), 5 of 5 licensed nursing staff from afternoon shift (2:00 p.m. to 10:00 p.m.), 1 of 2 licensed nursing staff from night shift (10:00 p.m. to 6:00 a.m.), 4 of 4 PRN licensed nursing staff, 2 of 2 weekend licensed nursing staff, and 3 of 3 administrative (MDS, ADON C, ADON D) licensed nursing staff. All 17 staff members reported they received education and were trained on behavioral monitoring, notifying the physician of behaviors, and reviewing and updating the residents' care plan. Attempted interview of RN G on 05/27/2024 at 06:19 p.m. and LVN A on 05/27/2024 at 7:11 p.m. to confirm training was unsuccessful. RN G worked morning shift (6:00 a.m. to 2:00 p.m.) and LVN A worked night shift (10:00 p.m. to 6:00 a.m.). (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with ADON D on 05/28/2024 at 10:48 a.m., ADON D stated she received training from the RDCS regarding behavioral monitoring and care planning, and she provided the training to ADON C and facility licensed nursing staff. ADON D stated the ADONs will be monitoring the psychosocial medications by reviewing the facility 24-hour, 72-hour, and Order Listing reports to identify if there were any new psychosocial medications, reported behaviors, new treatment orders, new antibiotic medications, new monitoring orders, and any reported behaviors. The report on incidents would also be reviewed. ADON D stated the reports would be reviewed in the morning clinical meeting with the floor nurses and ADON C, to discuss if any changes or incidents occurred the prior day and/or over the weekend. ADON D revealed that by reviewing the Order Listing report and 24-hour or 72-hour report, the ADONs were able to audit that if a new medication order was entered, a progress note for that new medication was entered, and verify that additional orders for monitoring the side effects, behaviors, and efficacy were entered. ADON D stated that by reviewing the Order Listing report and 24-hour or 72-hour report, the ADONs were able to review that when a PRN psychosocial medication was provided, a monitor for the behavior and efficacy was entered, and if needed, a progress note indicating that the physician was notified and description of the behavior or reason for providing the PRN medication was documented. ADON D stated that after the IJs were called, each residents' chart was audited for monitoring orders. ADON D stated that for some residents' charts, behavior monitoring, or side effect monitoring was found but not both, and for those residents the other monitor was added. ADON D revealed that the Psych NP was asked to also complete an audit, checking her records, and notes to verify that all the monitoring orders were in. She revealed for the care plan audit, she and the MDS nurse reviewed the care plans for every resident and ensured that the interventions in the care plans were also in the orders. ADON D stated they only identified Resident #1 as having the type of monitoring language for sadness and fear of being alone in his care plan. ADON D stated that it was discussed with the Psych NP on how the facility would going forward with their monitoring and interventions to reflect the facility's resident's needs and behaviors more accurately. In an interview with the RDCS on 05/28/2024 at 06:08 p.m., the RDCS stated she had attended Ad hoc QAPI Meetings on 05/25/2024 and 05/26/2024. The RDCS stated she provided training to ADON D on behavioral monitoring and care planning so ADON D could train the licensed nursing staff. In an interview with the MD E on 05/28/2024 at 12:36 p.m., MD E stated she had attended the Ad hoc QAPI Meetings on 05/25/2024 and 05/26/2024. MD E stated she was informed of the IJ and the plans for removal. In an interview with the Psych NP on 05/28/2024 at 01:44 p.m., the Psych NP stated she was notified of the IJ at the facility and was contacted by her supervisor regarding a request that she provide follow up assessments on specific residents to review current behaviors and monitoring orders. Interview with the ADMIN and record review of facility report Order Summary Report on 05/28/2024 at 04:50 p.m. revealed the facility staff did not create a tracking log of resident orders that were entered as a part of their plan of correction but stated the Order Summary Report dated start date 05/25/2024 with active orders as of 05/25/2024 captured the new orders created per the order audit. The report noted five (5) residents (Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) with new orders on 05/24/2024 or 05/25/2024 with start dates 05/25/2024. New orders included observation for anti-depressant medication, observation for anti-anxiety medication, monitor for depression, monitor for anxiety, and monitor for side effects of sedative/hypnotics. The ADMIN revealed a new psychosocial assessment was completed on the five (5) identified residents. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Record review of Resident #2's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), depression, and post-traumatic stress disorder (a condition characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). Record review of Resident #2's State Optional MDS, dated [DATE], revealed Resident #2 had a BIMS score of 99, which indicated the resident was severely cognitively impaired for daily decision-making skills and/or unable to complete the interview. Record review of Resident #2's MDS PHQ9 (Resident Mood Interview), dated 04/11/2024, revealed Resident #2 had a score of NA. Record review of Resident #2's care plan revealed: - A focus, initiated on 04/15/2024, revealed Resident #2 used antidepressant medication related to depression with interventions, date initiated 04/15/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad .suicidal ideations .fear of being alone or with others .anxiety . - A focus, initiated on 04/15/2024, revealed Resident #2 had impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions, impaired decision-making, long-term memory loss, psychotropic drug use, short term memory loss with interventions, date initiated 04/15/2024, Administer meds as ordered and Review medications and record possible causes of cognitive deficit .adverse drug reactions, drug toxicity. - A focus, initiated on 04/17/2024 and revised on 04/23/2024, revealed Resident #2 used anti-anxiety medications and anti-convulsant medications related to anxiety disorder with interventions, date initiated 04/17/2024, [Resident #2] is taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia .Monitor for safety, Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness .Paradoxical side effects: mania, hostility, and rage, aggressive or impulsive behavior, hallucinations, and Monitor/record occurrence of for target behavior symptoms and document per facility protocol. -A focus, initiated 04/15/2024, revealed Resident #2 had potential mood problems related to PTSD and dementia with intervention, date initiated 04/15/2024, Monitor/record/report to MD prn acute episode feelings or sadness . Record review of facility report Order Summary Report, start date on 05/25/2024 and active orders as of 05/25/2024, revealed two (2) orders for Resident #2, ordered on 05/24/2024 to start on 05/25/2024. The first order was: Observation: antidepressant medication- observe for behavior WITHDRAWN/ AGITATION. Observe for side effects .every shift. The second order was: Observation: antianxiety medication- observe for behavior AGITATION. Observe for side effects .every shift. (continued on next page)

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F 0742

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Record review of Psychosocial Assessment, dated 05/25/2024, revealed Resident #2 was unable to participate in assessment due to severe cognitive impairment directly related to admitting diagnosis of dementia. Resident remained at baseline. No adverse psychosocial effects noted. Plan of Care revealed continue with current care plan and psych services involvement. Provide quiet space if resident appears to become overstimulated. Monitor for adverse effects to psychosocial well-being.

2. Record review of Resident #3's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder, depression, and mild cognitive impairment (difficulty with language, memory, and thinking).

Record review of Resident #3's State Optional MDS, dated [DATE], revealed Resident #3 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision-making skills.

Record review of Resident #3's MDS PHQ9 (Resident Mood Interview), dated 01/03/2024, revealed Resident #3 had a score of 4, which indicated the resident was minimally depressed.

Record review of Resident #3's care plan revealed:

- A focus, initiated on 11/13/2023 and revised 05/07/2024, revealed Resident #3 had impaired cognitive function/ impaired thought processes related to difficulty making decisions, impaired decision making, mild cognitive impairment caused by history of alcoholic intoxication with interventions, date initiated 11/13/2023, Administer meds as ordered, Monitor/document/report to MD any changes in cognitive function ., and Review medications and record possible causes of cognitive deficit .adverse drug reactions, drug toxicity.

-A focus, initiated on 11/16/2023, revealed Resident #3 had potential psychosocial well-being problem related to illness/disease process, disease process with intervention, date initiated 11/16/2023, Consult with . Psych services, Other.

- A focus, initiated on 12/11/2023, revealed Resident #3 used antidepressant medication related to depression with interventions, date initiated 12/11/2023, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad .suicidal ideations .fear of being alone or with others .anxiety .

Record review of facility report Order Summary Report, start date on 05/25/2024 and active orders as of 05/25/2024, revealed two (2) orders for Resident #3, ordered on 05/24/2024 to start on 05/25/2024. The first order was: Depression: Monitor for depressive symptomology .every shift enter progress note describing behaviors observed if applicable. The second order was: Observation: antidepressant medication- observe for side effects .every shift.

Record review of Psychosocial Assessment, dated 05/25/2024, revealed Resident #3 remained at baseline for psychosocial well-being with no adverse effects noted. Plan of Care revealed continue with current care plan.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Record review of Resident #4's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), insomnia (trouble falling and/or staying asleep), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder, and suicide attempt, noted as initial encounter and dated 02/28/2024. Record review of Resident #4's State Optional MDS, dated [DATE], revealed Resident #4 had a BIMS score of 1, which indicated the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #4's MDS PHQ9 (Resident Mood Interview), dated 04/08/2024, revealed Resident #4 had a score of 4, which indicated the resident was minimally depressed. Record review of Resident #4's care plan revealed: - A focus, initiated on 02/28/2024 and revised on 05/18/2024, Resident #4 needed pain management and monitoring related depression with intervention, date initiated 02/28/2024, Observe for potential medication side effects. - A focus, initiated on 02/29/2024, revealed Resident #4 had impaired cognitive function/dementia or impaired thought processes related to dementia, difficulty making decisions, impaired decision making, psychotropic drug use, short term memory loss with interventions, date initiated 02/29/2024, Administer meds as ordered, Monitor/document/report to MD any changes in cognitive function ., and Review medications and record possible causes of cognitive deficit: .adverse drug reactions, drug toxicity. - A focus, initiated on 03/04/2024 and revised on 04/18/2024, revealed Resident #4 used anti-histamine medications related to adjustment issues and anxiety disorder with interventions, date initiated 03/04/2024, Give anti-anxiety medications ordered by physician. Monitor/documents side effects and effectiveness ., Monitor/record occurrence of for target behavior symptoms and document per facility protocol, and [Resident #4] is taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia .Monitor for safety. - A focus, initiated on 03/06/2024, revealed Resident #4 used antidepressant and antiseizure medication related to depression and poor adjustment to admission with interventions, date initiated 03/06/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad . suicidal ideations .fear of being alone or with others .anxiety . - A focus, initiated 03/13/2024, revealed Resident #4 was at risk for psychosocial well-being problems related to dependent behavior, lack of acceptance to current condition, recent admission, dementia, and depression with intervention, date initiated 03/13/2024, Consult with .Psych services. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- A focus, initiated 02/29/2024, revealed Resident #4 had potential mood problems related to dementia with behaviors and history or suicidal behaviors with interventions, date initiated 02/29/2024, Monitor/record/report to MD prn acute episode feelings or sadness ., Monitor/record/report to MD prn mood patters s/sx of depression, anxiety, sad mood as per facility behavior monitoring protocols, Monitor/record/r [TRUNCATED]

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46447

Based on observations, interviews, and record review, the facility failed to monitor based on the comprehensive assessment of a resident, residents who use psychotropic drugs for the efficacy and adverse consequences of prescribed psychotropic medications for 6 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) of 12 residents reviewed for medication management.

- The facility failed to monitor Resident #1 for side effects and observe for the behaviors of the antidepressant medication Sertraline HCl and the antianxiety medication Hydroxyzine HCl.

- The facility failed to monitor Resident #2 for side effects and observe for the behaviors of the antianxiety medication Ativan, the antidepressant medication Citalopram, and the anticonvulsant medication Trileptal.

- The facility failed to monitor Resident #3 for side effects and observe for the behaviors of the antidepressant medication Mirtazapine.

- The facility failed to monitor Resident #4 for side effects and observe for the behaviors of the anticonvulsant medication Depakote, the antianxiety medication Hydroxyzine HCl, the antidepressant medication Mirtazapine, and the antidepressant medication Trazodone.

- The facility failed to monitor Resident #5 for side effects and observe for the behaviors of the antianxiety medication Ativan and the anticonvulsant medication Valproic Acid.

- The facility failed to monitor Resident #6 for side effects and observe for the behaviors of the antidepressant medication Mirtazapine and the anticonvulsant medication Trileptal.

This failure could place residents at risk for adverse consequences such as dizziness, drowsiness, oversedation, agitation, restlessness, and suicidal thoughts related to the use of psychotropic medications.

Findings included:

Resident #1

Record review of Resident #1's Admission Record, dated 05/24/2024 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), depression, and anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder. Resident #1 was noted as discharged on [DATE] to an acute care hospital.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's State Optional MDS, dated [DATE], revealed the resident had a BIMS score of 8, which indicated the resident was mildly cognitively impaired for daily decision-making skills. The resident's PHQ9 (Resident Mood Interview) revealed the resident nearly every day showed little interest or pleasure in doing things, felt bad about himself, had trouble concentrating on things, moved or spoke so slowly that other people could have noticed or the opposite- been fidgety or restless, and had thoughts that he would be better off dead or of hurting himself in some way. Record review of Resident #1's care plan revealed: - A focus, initiated on 03/15/2024 and revised on 04/30/2024, revealed Resident #1 used anti-histamine medications related to anxiety/agitation with interventions, date initiated 03/15/2024, [Resident #1] is taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia .Monitor for safety and Monitor/record occurrence of for target behavior symptoms and document per facility protocol. - A focus, initiated on 03/19/2024, revealed Resident #1 used antidepressant medication related to depression with interventions, date initiated 03/19/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad .suicidal ideations .fear of being alone or with others .anxiety . Record review of Resident #1's Order Recap Report, dated 03/11/2024 - 05/31/2024 and accessed 05/21/2024, revealed Resident #1 had two (2) active psychotropic medications on the day of his discharge, 05/02/2024. - No orders were found for monitoring for target behavior symptoms or side effects and effectiveness for either medication. 1. An order for Hydroxyzine HCl Oral Tablet 24 MG, ordered and started on 04/29/2024, and ended on 05/13/2024. The order was for 1 tablet to be given by mouth every 12 hours as needed for anxiety and agitation for 14 days. 2. An order for Sertraline HCl Oral Tablet 50 MG, ordered 04/16/2024 and started on 04/17/2024. The order was for 1 tablet to be given by mouth one time a day for anxiety. Record review of Resident #1's MAR/TAR for April and May 2024 revealed side effects, effectiveness, or behaviors were not being monitored according to the care plan. Resident #1 was found to have received Sertraline HCl daily at 9:00 a.m. from 04/17/2024 - 05/01/2024, except on 04/20/2024 and 04/22/2024 and received Hydroxyzine HCl on 04/29/2024 at 9:22 p.m., on 09/30/2024 at 10:33 a.m., and on 05/01/2024 at 8:00 a.m. Resident #2 Record review of Resident #2's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), depression, and post-traumatic stress disorder (a condition characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's State Optional MDS, dated [DATE], revealed Resident #2 had a BIMS score of 99, which indicated the resident was severely cognitively impaired for daily decision-making skills and/or unable to complete the interview. The resident's PHQ9 (Resident Mood Interview) revealed the resident over the last two weeks, either never or just once, felt down, depressed, or hopeless, and felt tired or had little energy. Record review of Resident #2's care plan revealed: - A focus, initiated on 04/15/2024, revealed Resident #2 used antidepressant medication related to depression with interventions, date initiated 04/15/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad .suicidal ideations .fear of being alone or with others .anxiety . - A focus, initiated on 04/17/2024 and revised on 04/23/2024, revealed Resident #2 used anti-anxiety medications and anti-convulsant medications related to anxiety disorder with interventions, date initiated 04/17/2024, [Resident #2] is taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia .Monitor for safety, Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness .Paradoxical side effects: mania, hostility, and rage, aggressive or impulsive behavior, hallucinations, and Monitor/record occurrence of for target behavior symptoms and document per facility protocol. Record review of Resident #2's Order Recap Report, dated 04/10/2024 - 05/31/2024 and accessed 05/24/2024, revealed Resident #2 had three (3) active psychotropic medications on the day accessed. - No orders were found for monitoring for target behavior symptoms or side effects and effectiveness for the following medications. 1. An order for Ativan Oral Tablet 0.5 MG (Lorazepam), ordered on 05/22/2024, started on 05/23/2024, and no end date. The order was for 1 tablet to be given by mouth two times a day for anxiety. 2. An order for Citalopram Hydrobromide Oral Tablet 10 MG, ordered 04/30/2024 and started on 05/01/2024, and no end date. The order was for 1 tablet to be given by mouth in the morning for depression. 3. An order for Trileptal Oral Tablet 150 MG, ordered 04/29/2024 and started on 04/30/2024, and no end date. The order was for 1 tablet to be given by mouth two times a day for agitation. Resident #3 Record review of Resident #3's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder, depression, and mild cognitive impairment (difficulty with language, memory, and thinking). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's State Optional MDS, dated [DATE], revealed Resident #3 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision-making skills. The resident's PHQ9 (Resident Mood Interview) revealed the resident over the last two weeks did not experience any mood problems. Record review of Resident #3's care plan revealed: - A focus, initiated on 12/11/2023, revealed Resident #3 used antidepressant medication related to depression with interventions, date initiated 12/11/2023, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad .suicidal ideations .fear of being alone or with others .anxiety . Record review of Resident #3's Order Recap Report, dated 11/11/2023 - 05/31/2024 and accessed 05/24/2024, revealed Resident #3 had one (1) active psychotropic medication on the day accessed. - No orders were found for monitoring for target behavior symptoms or side effects and effectiveness for the following medication. 1. An order for Mirtazapine Oral Tablet 7.5 MG, ordered and started on 11/22/2023 and no end date. The order was for 1 tablet to be given by mouth at bedtime for depression and anxiety. Resident #4 Record review of Resident #4's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (a general term for impaired ability to remember, think, or make decisions), insomnia (trouble falling and/or staying asleep), major depressive disorder(a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness) disorder, and suicide attempt, noted as initial encounter and dated 02/28/2024. Record review of Resident #4's State Optional MDS, dated [DATE], revealed Resident #4 had a BIMS score of 1, which indicated the resident was moderately cognitively impaired for daily decision-making skills. The resident's PHQ9 (Resident Mood Interview) revealed the resident over the last two weeks, for 2 - 6 days, had trouble falling or staying asleep, slept too much, and had a poor appetite or overate. Record review of Resident #4's care plan revealed: - A focus, initiated on 03/04/2024 and revised on 04/18/2024, revealed Resident #4 used anti-histamine medications related to adjustment issues and anxiety disorder with interventions, date initiated 03/04/2024, Give anti-anxiety medications ordered by physician. Monitor/documents side effects and effectiveness ., Monitor/record occurrence of for target behavior symptoms and document per facility protocol, and [Resident #4] is taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia .Monitor for safety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A focus, initiated on 03/06/2024, revealed Resident #4 used antidepressant and antiseizure medication related to depression and poor adjustment to admission with interventions, date initiated 03/06/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad . suicidal ideations .fear of being alone or with others .anxiety . Record review of Resident #4's Order Recap Report, dated 04/04/2024 - 05/31/2024 and accessed 05/21/2024, revealed Resident #4 had four (4) active psychotropic medications on the day accessed. - No orders were found for monitoring for target behavior symptoms or side effects and effectiveness for the following medications. 1. An order for Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium), ordered and started on 04/09/2024 and no end date. The order was for 1 tablet to be given by mouth two times a day for agitation. 2. An order for Hydroxyzine HCl Oral Tablet 25 MG, ordered and started on 05/20/2024 and no end date. The order was for 1 tablet to be given by mouth every 8 hours for anxiety and agitation. 3. An order for Mirtazapine Oral Tablet 7.5 MG, ordered and started on 04/04/2024 and no end date. The order was for 1 tablet to be given by mouth at bedtime for depression. 4. An order for Trazodone HCl Oral Tablet 50 MG, ordered and started on 04/04/2024 an no end date. The order was for 1 tablet to be given by mouth at bedtime for insomnia. Record review of Resident #4's MAR/TAR for May 2024, accessed on 05/24/2024 at 6:18 p.m., did not reveal side effects, effectiveness, or behaviors were being monitored according to the care plan. Resident #4 was found to have received Depakote twice a day at 9:00 a.m. and 5:00 p.m. from 05/01/2024 - 05/22/2024, then twice a day at 7:00 a.m. and 7:00 p.m. on 05/23/2024, and one time at 7:00 a.m. on 05/24/2024. He received Hydroxyzine HCl twice on 05/20/2024 at 3:00 p.m. and 11:00 p.m.; then three times a day from 05/21/2024 - 05/23/2024 at 7:00 a.m., 3:00 p.m., and 11:00 p.m.; and twice on 05/24/2024 at 7:00 a.m. and 3:00 p.m. He received Mirtazapine and Trazodone HCl daily at 8:00 p.m. from 05/01/2024 - 05/23/2024. Resident #5 Record review of Resident #5's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included expressive language disorder (condition that affects the ability to use language to communicate), restlessness and agitation, and aphasia (inability to understand or express speech). Record review of Resident #5's State Optional MDS, dated [DATE], revealed the resident had a BIMS score of 00, which indicated the resident was severely cognitively impaired for daily decision-making skills. The resident's PHQ9 (Resident Mood Interview) revealed the resident was not able to be complete the interview. Record review of Resident #5's care plan revealed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A focus, initiated on 02/20/2024 and revised 02/23/2024, revealed Resident #5 used antidepressant and antiseizure medications related to depression with interventions, date initiated 02/20/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad . suicidal ideations .fear of being alone or with others .anxiety . - A focus, initiated 04/02/2024, revealed Resident #5 had potential for drug related complications associated with use of psychotropic medications anti-anxiety medication with intervention, date initiated 04/02/2024, Monitor for side effects related to psychotropic medications and report to physician . Record review of Resident #5's Order Recap Report, dated 01/01/2024 - 05/31/2024 and accessed 05/24/2024, revealed Resident #5 had two (2) active psychotropic medications on the day accessed. - No orders were found for monitoring for target behavior symptoms or side effects and effectiveness for the following medications. 1. An order for Ativan Oral Tablet 0.5 MG (Lorazepam), ordered and started on 04/09/2024 and no end date. The order was for 1 tablet to be given by mouth two times a day for anxiety and agitation. 2. An order for Valproic Acid Oral Solution 250 MG/5ML (Valproate Sodium), ordered on 04/29/2024 and started on 04/30/2024 and no end date. The order was for 5 ml to be given via PEG-Tube two times a day for agitation. Resident #6 Record review of Resident #6's Admission Record, dated 05/24/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), alcohol use, and opioid use. Record review of Resident #6's State Optional MDS, dated [DATE], revealed Resident #6 had a BIMS score of 14, which indicated the resident was cognitively intact for daily decision-making skills. Record review of Resident #6's care plan revealed: - A focus, initiated on 02/23/2024 and revised 04/12/2024, revealed Resident #6 used antidepressant and anticonvulsant medication related to depression with interventions, date initiated 02/23/2024, Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness ., and Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad . suicidal ideations .fear of being alone or with others .anxiety . Record review of Resident #6's Order Recap Report, dated 11/10/2023 - 05/31/2024 and accessed 05/24/2024, revealed Resident #6 had two (2) active psychotropic medications on the day accessed. - No orders were found for monitoring for target behavior symptoms or side effects and effectiveness for the following medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. An order for Mirtazapine Oral Tablet 7.5 MG, ordered and started on 12/13/2023 and no end date. The order was for 1 tablet to be given by mouth at bedtime for depression and anxiety. 2. An order for Trileptal Oral Tablet 150 MG (Oxcarbazepine), ordered and started on 04/09/2024 and no end date. The order was for 1 tablet to be given by mouth two times a day for mood. Ativan Oral Tablet 0.5 MG (Lorazepam), ordered and started on 04/09/2024 and no end date. The order was for 1 tablet to be given by mouth two times a day for anxiety and agitation. In an interview with the Psych NP on 05/23/2024 at 4:33 p.m., the Psych NP stated the nursing facility had standard orders for the psychotropic medications, orders that the nurses at the facility follow. The Psych NP stated she was unsure how the psychotropic monitoring orders were generated but stated that the staff were pretty good about monitoring their residents. The Psych NP stated the facility staff were really good at notifying her of any issues by calling her or would tell her when she was in the facility for her assessments, which was generally at least one time a week. The Psych NP stated that the majority of residents at the facility were psychiatric patients, so the nurses would report to her continuously of the resident's behaviors. The Psych NP stated that she did not feel that there had to be an order for monitoring because the nurses knew to call her or call the call center, which could be reached 26 hours a day, seven days a week. In an interview with MD E on 05/25/2024 at 12:52 p.m., MD E stated the nursing staff monitored and checked on residents daily so they would chart if there were any changes. MD E stated she felt the residents were being monitored adequately and if there was a change, the staff would have reported those changes. In an interview with LVN B on 05/26/2024 at 4:15 p.m., LVN B stated she monitored for side effects based on the specific medications. LVN B stated she looked at what was entered into the facility's MAR to know what to look for. LVN B stated she monitored her residents for having signs and symptoms, and if they did, she reported it to the doctor. LVN B stated she documented her observations in a note and completed a change of condition form. LVN B stated if a resident were having behaviors, she would document those behaviors. Record review of the facility's policy, Behavioral Monitoring, revised March 2019, revealed 6. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes . Monitoring .4. If antipsychotic medications are used to treat behavioral symptoms, the IDT, incoordination, and alongside behavioral health services, will monitor their indication .a. The IDT and behavioral health services will monitor for side effects and complications related to psychoactive medications .b. if such symptoms are identified, and some medication is still needed, the IDT and behavioral health services will adjust the current regimen to try to minimize side effects while maintaining therapeutic effectiveness.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on observations, interviews, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 44% based on 11 errors out of 25 opportunities, which involved 1 (Resident #7) of 4 residents reviewed for medication errors. CMA H failed to administer medication as ordered to Resident #7 by administering Amlodipine (a treatment for high blood pressure), Buspirone HCl (a treatment for mood disorder), Calcium-Vitamin D supplement, Clonidine (a treatment for high blood pressure), Docusate Sodium (a treatment for constipation), Divalproex Sodium (a treatment for mood disorder), Furosemide (a treatment for edema or fluid retention), Metoprolol Tartrate (a treatment for high blood pressure), Multivitamin, Sodium Supplement, Spironolactone (a treatment for edema or fluid retention) over 11/2 hours after the scheduled time. These failures could place residents at risk of not receiving the desired therapeutic effect of their medications and uncontrolled pain. Findings included: Record review of Resident #7's Admission Record, dated 05/23/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paranoid schizophrenia (a chronic mental illness involving symptoms of schizophrenia and characterized by symptoms such as a persistent and irrational fear or suspicion of others, delusions, and hallucinations), atherosclerotic heart disease (a buildup of fats in the arterial walls), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), localized edema (swelling caused by excess fluid trapped in the body's issues), and constipation. Record review of Resident #7's MDS, dated [DATE], revealed Resident #7 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision-making skills. Record review of Resident #7's May MAR revealed, Resident #7's Lasix Tablet 40 MG (Furosemide), Norvasc Tablet 10 MG (Amlodipine Besylate), Aldactone Tablet 50 MG (Spironolactone), Buspirone HCl Tablet 5 MG, Calcium Carbonate-Vitamin D Tablet 600-400 MG, Clonidine HCl Tablet 0.1 MG, Colace Capsule 100 MG (Docusate Sodium), Depakote ER Tablet Extended Release 24 Hour 500 G (Divalproex Sodium ER), Metoprolol Tartrate Tablet 25 MG, Multivitamin with Minerals Tablet, and Sodium Chloride Tablet was scheduled for 7:00 a.m. Record review of Resident #7's Order Summary Report, dated as Active Orders as of 05/23/2024 and accessed on 05/23/2024, revealed Resident #7 orders included: - An order for Aldactone Tablet 50 MG (Spironolactone), ordered and started on 02/16/2022 and no end date. The order was for 1 tablet to be given by mouth two times a day for edema. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for Buspirone HCl Tablet 5 MG, ordered 12/28/2020 and started on 12/30/2020 and no end date. The order was for 1 tablet to be given by mouth two times a day for anxiety. - An order for Calcium Carbonate-Vitamin D Tablet 600-400 MG-UNIT, ordered and started on 04/17/2019 and no end date. The order was for 1 tablet to be given by mouth two times a day for supplement. - An order for Clonidine HCl Tablet 0.1 MG, ordered and started on 11/16/2022 and no end date. The order was for 1 tablet to be given by mouth two times a day for hypertension (high blood pressure) and to be held if systolic blood pressure was below 110, diastolic blood pressure was below 60, and/or heart rate was below 60. - An order for Colace Capsule 100 MG (Docusate Sodium), ordered and started on 01/11/2022, and no end date. The order was for 1 capsule to be given by mouth two times a day for bowel management. - An order for Depakote ER Tablet Extended Release 24 Hour 500 MG (Divalproex Sodium ER), ordered and started on 09/08/2020, and no end date. The order was for 1 tablet to be given by mouth two times a day for Schizophrenia. - An order for Lasix Tablet 40 MG (Furosemide), ordered and started on 09/28/2020, and no end date. The order was for 1 tablet to be given by mouth in the morning for edema. - An order for Metoprolol Tartrate Tablet 25 MG, ordered and started on 09/28/2020, and no end date. The order was for 1 tablet to be given by mouth two times a day for hypertension and to be held if blood pressure was below 100/60 and/or pulse below 60. - An order for Multivitamins with Minerals Tablet, ordered and started on 09/23/2020, and no end date. The order was for 1 tablet to be given by mouth two times a day for health supplement. - An order for Norvasc Tablet 10 MG (Amlodipine Besylate), ordered on 07/05/2023 and started on 07/06/2023, and no end date. The order was for 1 tablet to be given by mouth one time a day for blood pressure and to be held if systolic blood pressure was below 110 and/or heart rate was below 60. - an order for Sodium Chloride oral Tablet 1 GM (Sodium Chloride), ordered on 05/22/2024 and started on 05/23/2024, and no end date. The order was for 2 tablets to be given by mouth two times a day related to hypo-osmolality (low levels of electrolytes, proteins, and nutrients in the blood) and hyponatremia (low levels of sodium in the blood). In an interview with CMA H on 05/22/2024 at 7:55 a.m., CMA H stated that she started her shift at 6:00 a.m., and after completing her cart counts, she started passing medications around 6:30 a.m. every day. CMA H stated that due the number of residents she was assigned with medications scheduled at 7:00 a.m., she had late administrations daily. CMA H stated that she started her medication administration on E-hall, but by the time she reached F-hall, the medications scheduled on F-hall for 7:00 a.m. were late. CMA H stated that she had reported the late medication administrations to the shift nurses, did not provide names, but had not told the ADONs, the prior DON, or the ADMIN. (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CMA H on 05/22/2024 at 8:28 a.m., revealed CMA H preparing medication for administration to Resident #7 with the resident's MAR red indicating late medication administration on the EHR. CMA H confirmed the red in the MAR indicated the medication administration was late. CMA H administered the medications to Resident #7 at 08:35 a.m. Interview with MD E 5/25/2024 at 12:52 p.m., MD E stated medications had a two-hour window for administration. After review of the medications administered late to Resident #7 and the time of order and administration, MD E stated she did not have any concerns about side effects or medication interactions with the subsequent issuances or timeliness for this amount of time late. Record review of the facility's policies, Medication Orders, dated revised November 2014, and Documentation Medication Administration, dated revised November 2022, did not reference administration timeliness or late medication administration.