

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455908	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/13/2024
NAME OF PROVIDER OR SUPPLIER  Schulenburg Regency Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  111 College St Schulenburg, TX 78956	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884</b></p> <p>Based on interview and record review, the facility failed to ensure the residents had the right to be free from resident neglect for one</p> <p>(Resident #12) out of three residents reviewed for neglect.</p> <p>The facility failed to ensure FTA from ensuring the facility lift was located at the back facility door to transfer Resident #12 off the van onto the lift . Resident #12 fell from the van onto the lift located on the ground on 11/15/2024.</p> <p>This noncompliance was identified as PNC. The deficient practice occurred on 11/15/2024 and in-service was completed on 11/15/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of neglect, injury, and psychosocial harm.</p> <p>Findings included:</p> <p>Record review of Resident # 12's face sheet, dated, 12/11/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #12 had diagnoses which included vascular dementia ( a condition that affects the brain's ability to think, remember, caused by lack of blood flow to the brain), type 2 diabetes with diabetic neuropathy, acute respiratory failure with hypoxia ( a medical condition where the body's ability to take in oxygen is suddenly impaired, leading to a dangerously low level of oxygen in the blood. Hypoxia can be life-threatening), muscle weakness ( a lack of muscle strength that makes it difficult to move your body),glaucoma ( buildup fluid in the front of the eye, which increases pressure inside the eye. If left untreated can lead to vision loss and eventually blindness), and type 2 diabetes with diabetic neuropathy ( when nerve damage develops due to long-term high blood sugar levels).</p> <p>Record review of Resident #12's Annual MDS Assessment, dated 10/07/2024, reflected the resident had a BIMS score of 4, which indicated her cognition was severely impaired. Resident #12 required assistance with transfers, dressing, hygiene, and showers.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #12's Comprehensive Care Plan, completed on, 11/18/2024, reflected Resident #12 had Impaired physical mobility. Intervention: Assist resident in performing movements and tasks. Educate Resident and Representative on safety precautions. Educate resident and representative on safe transfer techniques. Resident #12 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to some cognitive deficits (related to mental process involved in knowing, learning, and understanding things) and safety concerns. Resident #12 required assistance with most aspects of ADL s. Intervention: Transfers: Resident #12 required one person assist with difficult transfers related to weakness. Resident #12 was at risk for falls. Resident #12 had a fall incident with transportation van on 11/15/2024 and was evaluated at emergency room with laceration and hematoma to back of head. Interventions: anti-roll back to wheelchair. Staff education on safe operation of van with loading and unloading residents. Van maintenance for proper function of the transportation van.</p> <p>Record review of Resident #12's nurses note dated 11/15/2024 at 3:30 PM reflected called by transportation driver to the front awning. Seen resident laying on her left side. Resident was assisted into a sitting position. Resident stated she hit her head and it was hurting her. Small laceration and formation of hematoma was noted to the back of her head. Resident complained of pain to her bottom but denied pain anywhere else. Upon further assessment, no other injuries noted. Focused neuro assessment was completed, resident was alert and oriented , Vitals BP- 140/90, P-92, Respiration- 24, Temperature- 98.6, O2- 100 % RA. Assessed residents ROM, WNL of resident's baseline. EMS was called, R/P, MD, DON , and Administrator notified. Resident consented to transport. Signed by RN A.</p> <p>Record review of the facility investigation report, dated 11/18/2024, reflected Transportation Aide T failed to raise the lift prior to rolling Resident #12 out of the van resulting in resident falling out of the rear exit of the van. The investigation was confirmed, and Transportation Aide T was terminated.</p> <p>Record review of Resident #12's incident report, dated 11/15/2024, reflected called by transportation driver to the front awning. Seen resident laying on her left side. Resident stated she hit her head and it was hurting. Small laceration and formation of hematoma to the back of her head. Resident complained of pain to her bottom but denied pain elsewhere. No other injuries noted. Resident stated I fell out the back of the van. Resident noted to be anxious. Resident knew where she was and able to inform the nursing staff her name and date of birth. The following was documented on the incident report:</p> <ol style="list-style-type: none"> <li>1. Immediate action taken: Resident sent to local hospital by EMS.</li> <li>2. Injuries observed at the time of incident: laceration to the back of head.</li> <li>3. Level of Pain: Resident #12's pain level was a 10 (on scale of 1 to 10 and 10 being the maximal level of pain). Resident #12 was alert.</li> <li>4. Mental Status: Resident #12 was oriented to the following: person, situation, place and, time.</li> <li>5. Injuries report post incident: Resident #12 did not have any observed post incident.</li> <li>6. Witnessed fall: Resident #12 fell outside.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/10/2024 at 9:45 AM Transportation Coordinator stated Transportation Aide T came into the facility and asked for a nurse immediately. Transportation Coordinator stated few nurses went outside and she heard people talking and she immediately went outside. She stated when she arrived outside under the awning near the front door was the Van ( white dodge van). Transportation Coordinator stated she saw Resident #12 on the ground and there were two or three nurses assessing Resident #12. She stated she spoke with Transportation Aide T, and she was very upset. She stated Transportation Aide T explained what happened with Resident #12. Transportation Coordinator stated she wrote a statement of what Transportation Aide T stated what occurred and she did not think to get Transportation Aide T to sign the statement. ( The statement is listed above this interview). Transportation Coordinator stated she could understand how the statement could be confusing. She stated Transportation Aide T left the lift ( ramp) on the ground after unloading Resident #48. She stated after Transportation Aide T Escorted Resident #48 into the facility she returned to the van and entered from the side door. Transportation Coordinator stated Transportation Aide T unhooked all the belts and safety devices from Resident #12 wheelchair. She stated Transportation Aide T was facing Resident #12 and was pushing her backwards to the open door in the back of the van. Transportation Coordinator stated Transportation Aide T did not have the lift to the van door. She stated Resident #12 back was facing the open door and Transportation Aide To push resident off the van and Resident #12 fell from the van onto the lift located on the ground. She stated she was informed by the Administrator to escort Transportation Aide T to get a drug test. Transportation Coordinator stated after the drug test she escorted her into the Administrator's office and Transportation Aide T was terminated immediately. Transportation Coordinator stated she had been in this position after Transportation Aide T was hired. She stated the former Transportation Coordinator U Trained Transportation Aide T. She stated all staff hired as transportation aides are trained 2 weeks or more before they can drive the vans. She stated there were two facility vans one is a [NAME] Dodge Caravan and this was the one Resident #12 was in when she fell . She stated there was another van a Green/Gray [NAME]. Transportation Coordinator stated all staff on the insurance card had been re-trained on how to operate the vans uploading and unloading on 11/18/2024. She stated there was a new hire on 12/02/2024 as a full-time van driver. Transportation Coordinator stated the new van driver received training on how to operate the van on 12/02/2024 and for 2 weeks prior to Transportation Aide S drove the van. She stated Transportation Aide S and any new hires received training and would observe the current Transportation Aide R before she drove the van. Transportation Coordinator showed her list of staff on the insurance card, and it matched the administrations list. Transportation Coordinator stated everyone on that list had been in serviced verbally and given form of steps for operating the lift on the vans and the staff had to demonstrate how to operate the van on an individual basis. She stated this was the first time Transportation Aide T had an accident/ incident with unloading a resident off the van. Transportation Coordinator stated she was not aware of any transportation aides or anyone driving the vans having an incident.</p> <p>Interview on 12/10/2024 at 1:00 PM Transportation Aide S stated she was hired on 12/02/2024 as a full-time transportation aide. She stated she did not work at this facility prior to being hired on 12/02/2024. Transportation Aide S stated she was given in-service and training over a week before she began driving the van. She stated she observed Transportation Aide R drive the van and observed residents being unloaded and uploaded on to the vans. She repeated how to upload a resident onto the van and unload a resident off the van. She stated she was in-serviced on resident neglect.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/12/2024 at 1:35 PM the Administrator stated Transportation Aide T, had returned to the facility in the facility white van with 2 residents from doctor appointments. Transportation Aide T Unloaded Resident # 48 off the facility van with the lift. She stated when Transportation Aide T returned to the facility van, she did not enter the van per facility protocol. The Administrator stated Transportation Aide T did not stand on the lift and move the lift from the ground to the back open door. She stated Transportation Aide T was required per policy to stand on the lift and maneuver the lift from the ground to the back door to use to transfer Resident #12 from the facility van onto the ground. Transportation Aide T entered the facility van from the side door and proceeded to unhook the straps and belts from Resident #12's wheelchair. Transportation Aide T pushed Resident #12 wheelchair to the open door where the lift was not at the back door. Transportation Aide T was facing Resident #12 and Resident #12's back was to the open door. She stated Transportation Aide T did not notice she had not moved the lift from the ground to the open door. The Administrator stated Transportation Aide T pushed Resident #12 backwards where Resident #12's back was facing the door and pushed her off the van. The Administrator stated it was approximately 3 or 4 feet. She stated Resident #12 fell from the facility van onto the lift located on the ground. She stated the lift was not used to assist Resident #12 off the facility van. The Administrator stated the facility protocol for unloading residents onto the lift of the van was not followed. She stated the white van was used during the incident with Resident #12 was in the shop at a dealership for repair. She stated the repair was not the lift. The Administrator facility staff checked the lift after the incident, and it did not have any mechanical issues. The lift was in good condition. The Administrator did not specify what staff checked the lift.</p> <p>In an interview on 12/12/2024 at 3:30 PM Resident #12 stated she did fall out of a van, and it was a long fall. She stated she was not hurt and was happy she did not break any bones. Resident #12 stated she was not afraid to ride on the van again. She stated accidents happens and she was lucky. Resident #12 stated she would ride the van anytime she was not afraid and was not nervous over the fall from the van.</p> <p>In an interview on 12/12/2024 at 3:45 PM Transportation Coordinator stated the protocol listed below was the facility protocol for unloading a resident off the van.</p> <p>Record review of the facility's protocol for Unloading Transportation Vans, not dated, reflected the following:</p> <ol style="list-style-type: none"> <li>1. When unloading a resident, the resident is to be pushed onto the ramp, brakes engaged, and the driver is to ride down the ramp in front of the resident until the ramp is fully down and immobile on the ground.</li> <li>2. Ensure that wheelchairs are always locked when not actively moving a resident .</li> <li>3. Residents are required to have their wheelchairs secured in the van and the resident is to be wearing a seat belt.</li> <li>4. Before unloading a resident, make sure the ramp is up all the way and ready for the resident to be pulled onto the ramp.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. While unloading the van when transferring two residents, be sure to leave the resident not being unloaded at the same time secure in the van and have their wheelchair locked until ready to unload them.</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872</b></p> <p>Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property for 1 of 5 residents (Resident #38) reviewed for misappropriation of property.</p> <p>The facility failed to prevent the misappropriation of Resident #38's Hydrocodone-Acetaminophen, a medication to help with pain.</p> <p>This failure could place residents at risk for not receiving prescribed medications.</p> <p>Findings included:</p> <p>Record review of Resident #38's admission record dated 12/12/24, reflected the resident was admitted [DATE]. Her diagnoses included dysphagia (difficulty swallowing), cerebral infarction (stroke), Rheumatoid arthritis (the immune system attacks the body's tissues, leading to swelling and joint deformity and pain), and pain.</p> <p>Record review of Resident #38's quarterly MDS dated [DATE] reflected a BIMs score of 0 indicating severe cognitive impairment.</p> <p>Record review of Resident #38's physician orders dated 11/3/24 reflected an active order for Hydrocodone-Acetaminophen 5-325mg 1 tablet oral every 24 hours as needed for pain.</p> <p>Record review of Resident #38's Medication Administration Record (MAR) dated 11/1/23 through 11/30/24 reflected the Hydrocodone-acetaminophen had not been administered at all.</p> <p>Record review of the facility's investigation of the missing hydrocodone-acetaminophen medication reflected on 11/03/24 during the shift change around 6AM the oncoming nurse noted a difference in color for 5 of the 60 tablets in the bottle. The charge nurse was notified. The charge nurse was not able to address the situation for some time but once she assessed the situation the on-call nurse and ADM were notified. The off going nurse that worked night shift had already left the facility and refused to return to perform a urine drug screen. The medications were found to be Imdur 60mg tab. No other resident in the facility had an order for Imdur.</p> <p>Record review of the Pharmacy consultant's notes dated 11/11/24 revealed, DON reported a discrepancy in bottle of Norco 5/325 generic. Bottle contained 60 tablets, but 55 were identified by ID on bottle and Ephorates app as Hydrocodone/Appa 5/325 as dispensed and 5 of the 60 were noted to be Isosorbide Mononitrate 60mg tablets-per ID on the tablets, and per Drugs.com.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/12/24 at 9:28 AM with LVN E, she stated she had worked at the facility for about a year. She stated that all controlled medications are to be counted when possession of responsibility for the cart changes. LVN E stated the first page in the count binder is a record of how many medications there are to be counted. Once the correct number of medications is verified then the quantity of each medication must match up to its paired sheet. LVN E stated if anything is off with the count or suspicion of anything not matching up correctly then it is to be reported to the DON immediately. She stated missing medications could mean that a resident does not get the medication when they are supposed to.</p> <p>During an interview on 12/12/24 at 9:53 AM with LVN F, she stated she had worked at the facility for about 4 years. She stated that all medication carts are to be counted before changing shifts. She stated that if anything is off with the count, then the DON is to be notified immediately. She stated if there are medications missing then it could affect the resident by causing a missed dose.</p> <p>A telephone message was left on 12/12/24 at 1:00 PM for Family member of Resident #38 requesting a return call. A return call was not received before close of business 12/13/24.</p> <p>During an interview on 12/12/24 at 2:39 PM with the DON, she stated she was notified a few hours after shift change about the medication being a different color and possible different pill. She stated that her investigation revealed that during the shift change it was discovered that 5 pills in a bottle of 60 pills were with a different color and imprint than the other 55 pills. The DON stated that the off-going nurse (LVN W) on that day when this discrepancy was revealed refused to do a urine drug screen and has been terminated from employment with this facility. She stated that she contacted the physician, the consultant pharmacist, the resident's responsible party, the dispensing pharmacy and the sheriff's office to make a report. The DON stated the 5 other pills were identified as isosorbide mononitrate 60mg using drugs.com as a reference. She said that she looked and no one in the building at that time was prescribed that medication and dosage. She stated that she has since in serviced staff that she is to be notified immediately and no one is to leave the building until further instructed. The DON stated that her investigation into the missing medication was considered confirmed. She stated that this could have impacted the resident if she had received the wrong medication, it could have caused harm.</p> <p>During an interview on 12/12/24 at 3:04 PM with the ADM, she stated Resident #38's family took her to the doctor in another city and returned with a bag from an outside pharmacy with a bottle of medication in the bag in October. The medication was counted and verified by staff. She stated, they asked their pharmacy to repackage it into a blister pack, but they would not do it because it was filled at a different pharmacy. After the incident, Resident #38's chart was reviewed, and it reflected no medication had been administered since the order was written. She stated the incident was reported to the police and the nurse that worked that night (LVN W) refused to do a urine drug screen and that nurse was terminated. The ADM stated it could have affected the resident if she had taken the medicine, but she looked back over Resident #38's medication administration record and the resident never received any medication from that bottle.</p> <p>Record Review of Policy titled Storage of Medications dated 2001 and revised in November 2020 states,</p> <p>Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8. Schedule II-V controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50001</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #109) of 4 residents reviewed for elopement on 10/27/24.</p> <p>The facility failed to put interventions in place to prevent Resident #109 from eloping from the facility when she walked out of the memory care unit and exited the fire alarm gate on 10/27/24. Resident #109 was found by an exit door again on 12/01/24 . Resident has history of opening the doors after pushing on them for 15 seconds allowing the door to open.</p> <p>An IJ was identified on 12/12/24. The IJ template was provided to the facility on [DATE] at 3:30 PM. While the IJ was removed on 12/13/24, the facility remained out of compliance at a scope of isolated and severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This deficient practice could place residents at risk for unsafe elopements, injuries, and hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #109's admission record, dated 12/12/24, reflected she was an [AGE] year old female who initially admitted to the facility on [DATE], and had diagnoses including Alzheimer's disease (a brain disorder that causes a gradual decline in memory, thinking, and reasoning skills), Hypokalemia (a condition where the potassium levels in the blood are lower than normal), Hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs), Hyperlipidemia (a condition where there are abnormally high levels of lipids (fats) in the blood), Essential primary hypertension (a type of high blood pressure that develops gradually over time and has no clear cause), Chronic atrial Fibrillation (a type of heart arrhythmia that causes the upper chambers of the heart to beat irregularly and quickly), unspecified atrial fibrillation (a heart condition where the upper chambers of the heart beat irregularly and out of sync with the lower chambers), seasonal allergic rhinitis (an inflammatory condition of the upper airways that occurs when the immune system overreacts to airborne allergens), constipation (a bowel dysfunction that makes it difficult or infrequent to have a bowel movement), primary osteoarthritis (is a type of arthritis that develops in joints over time and has no known cause), abnormalities of gait and mobility (any deviation from a normal walking pattern, which can manifest as difficulties with balance, coordination, or the rhythm of walking, often caused by underlying neurological, musculoskeletal, or sensory issues, leading to symptoms like limping, shuffling, dragging feet, or an unsteady gait), Altered mental status (a general term that describes a change in how well the brain is working) and cognitive communication deficit (a communication difficulty caused by a cognitive impairment).</p> <p>Review of Resident #109's comprehensive MDS assessment, dated 10/16/24, reflected a BIMS of 2 indicated severe cognitive impairment. MDS review reflected wandering - Presence and Frequency: Resident score 1 indicating behavior of this type occurred 1 to 3 days.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #109's care plan, dated 10/11/24, reflected Resident #109 has impaired cognitive function with potential for worsening cognition related to progression of disease along with adjusting to new environment. Staff were instructed to keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion. Resident #109 is an elopement risk/wanderer related to disoriented to place, Impaired safety awareness. Staff were to maintain resident's safety will be maintained through the review date .</p> <p>Review of Resident #109's progress notes, from 10/10/24 through 12/1/24 , reflected,</p> <p>-A note by RN A on 10/10/24 at 5:09 AM, Late entry, which stated, behaviors: Wandering, Chronic. There have not been any recent medication reductions.</p> <p>-A note by LVN I on 10/10/24 at 1:54 PM, stated admission details: Mental Status: Resident is confused. Resident is inattentive. Resident is experiencing signs of short-term memory loss. Resident is disorganized in thinking. Oriented to person. Confused: Chronic. Short term memory loss: Chronic. Safety: Utilizing wander elopement alarm.</p> <p>-A note by LVN T, on 10/11/2024 at 10:54 AM, stated elopement evaluation: history of elopement while at home. Yes. Wandering behavior, a pattern or goal directed. Yes. Wanders aimlessly or non-goal-oriented: No. Wandering behavior likely to affect the safety or well-being of self/others: No. Wandering behavior likely to affect the privacy of others. No. Recently admitted or readmitted (within past 30 days) and has not accepted the situation: No. Elopement Score: 5.0 Score of 5.0 means: High risk of elopement.</p> <p>-A note by LVN E, on 10/13/2024 at 11:10 AM stated, note text: Resident exit seeking currently. Resident pushed on doors until they came open. Resident walked through doors down hall. RN charge and I were able to redirect resident back onto secure unit, with no resistance. Directed resident to her room.</p> <p>- A note by LVN E, on 10/13/2024 at 2:57 PM stated, note text: Resident in exit seeking, in search of her car to go home. Redirected resident to different activities with other residents. Redirection effective currently. Will continue with current plan of care.</p> <p>- A note by LVN E, on 10/13/2024 at 3:52 PM stated, Mood and behavior: Resident is currently experiencing unwanted behaviors. Wandering: Chronic. Mood and behavior note exit seeking.</p> <p>-A note by LVN U, on 10/13/2024 at 8:00 PM stated, note text: Noted with restlessness. Continuously pacing up and down hallway attempting to exit out of locked doors. Has held door long enough to release lock multiple times with staff able to redirect. Continues to state, I need to get to the parking lot and get my grey [NAME]. I am sorry but I am not staying here, especially when I do not belong here. Staff attempt to re-orient resident with no success. Staff continues to redirect currently. Plan of care to continue.</p> <p>- A note by LVN I, on 10/15/2024 at 6:19 PM stated, Behavior notes: Noted with increased restlessness/agitation/exit-seeking - repeatedly ambulating to double doors while stating, I need to go home, I have work to do at home. Initially easily redirected though required x2 staff to redirect from exiting and to dining area for supper. Noted confusion increasing when interacting with peers- staff able to direct to dining area for supper. RP made aware of behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- A note by LVN V, on 10/27/2024 at 1:29 PM stated, note text: Resident was found around back of building approximately at 11:48 am. Resident was redirected back into the building by staff in which she was easily redirected without incidence. Resident assessed and noted no visible injuries, vitals taken 142/76/77, temperature 97.2, respiration rate 18. Skin warm, dry and intact. Resident states she had not been outside today. When question was asked resident stated she followed someone out of the gate and around the building, she also stated she goes out there numerous times. All parties are made aware including, MD, Representative, DON and administration. Resident eats her lunch and remains at table until family arrives.</p> <p>-A note by DON, on 10/27/2024 at 2:55 PM , indicates note strike out reason from resident chart: Incorrect documentation. Note text: After review of camera footage; resident noted to be outside for approximately one hour. Weather noted to be 94 degrees. Notified Medical Director Received new orders for labs to be drawn when resident arrives back at facility for CBC, CMP. Diagnosis: Fatigue. Representative made aware of new orders.</p> <p>-A note by DON on 10/27/2024 at 3:00 PM, stated Note text: after review of the camera footage and time stamp; resident noted to be out of sight for 14 minutes . Medical Director updated.</p> <p>-A note by LVN E on 12/01/2024 at 03:46 PM, stated nurse note: Resident was observed at exit doors. Resident pushed on doors until they came open. Resident came through doors to other side. Nurse intervened and assisted in getting resident back on the other side.</p> <p>Review of Resident #109's admission wandering evaluation, dated 10/11/24, reflected she had a history of wandering/elopement. There were no goals or interventions notated on the evaluation for Resident #109.</p> <p>Review of Resident #1's plan of care, from 10/11/24 through 11/03/24, reflected Resident #109 exhibited Problem: The resident is an elopement risk/wanderer related to disoriented to place, impaired safety awareness. 10/27/2024: Resident found outside back of building with no injuries (resident states she followed someone out of gate). Interventions/Tasks: Resident to reside on secured unit. Staff education regarding elopement/wandering with new policy regarding elopement. Date initiated: 10/27/2024. Wander alert: resident may have wander guard applied to alert staff of attempts to exit to facility; check placement and functioning every shift. Problem: The resident has impaired cognitive function with potential for worsening cognition related to progression of disease along with adjusting to new environment. Interventions/tasks: Administer medications as ordered. Monitor/Document for side effects and effectiveness (Namenda and Aricept). Keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility's investigation file for Resident #109's incident on 10/27/24 reflected on 10/27/24, ADM investigation summary indicated review of camera footage. Resident observed exiting back door at 11:33 am. Resident noted exiting gate at 11:33 LVN V, observed walking out to the porch and to gate that is sounding at 11:35 am. Resident was escorted back to memory care wing at 11:49 am. Head to toe assessment performed, no injuries noted. Medical Director notified. Resident family member notified. Received new lab orders from doctor. Residents assessed and note no visible injuries, vitals taken 142/76/77, temperature 97.2, respirations 18. Skin was dry and intact. Resident states she had not been outside today. Resident eats her lunch and remains at table until family arrives as resident was scheduled to go out on pass this day to watch family member's theater performance. Action taken 10/27/24: Dementia training with appropriate interventions. Abuse and Neglect. Elopements. State reportable. 300 hall education: No propping open door, roller shades to be open. 10/28/24 Wander guard system placed for additional monitor placement on exit gate. Created new policy and procedure to follow for when exit alarms sound that include nursing staff conducting a roll call for all residents.</p> <p>During an interview on 12/11/24 at 9:50 AM, LVN H stated Resident #109 was outside in the smoking area. LVN H noticed her outside and realized that she was a little confused and then realized she was a resident from the facility. She was standing outside the gate; the gate was propped open in the smoking rest area for residents. LVN H redirected the resident back inside. LVN H verbalized, I'm not sure how long she was outside, I didn't see her when I passed by the window but when I went outside to take a break, I noticed her outside, it could not have been that long voiced LVN H.</p> <p>During an interview on 12/12/24 at 9:36 AM, LVN V stated she was the charge nurse for the memory unit on 10/27/24. She verbalized that staff were not very familiar with Resident #109 and the resident's family member had called that morning and asked that the staff get the resident ready for an outing. Staff got the resident ready and that morning staff had residents out in the outside area enjoying the weather. LVN V verbalized she is not sure if the resident was with the group but when the staff brought the residents back in shortly after the gate alarm went off outside. LVN V voiced she went out to check the gate and it was closed. She said she did not see anyone outside, so she closed the door that was left propped open during the process of bringing the residents back in that morning. LVN V verbalized she just thought someone pushed up on the gate and that is why the alarm went off. So, she turned the alarm off. LVN V, voiced another nurse came up to her at one point and told her he found one of her residents near the smoking area. LVN V provided a skin assessment on the resident and notified the doctor and family. LVN V, voiced she thinks the resident was gone for about 10 to 15 minutes. LVN V, verbalized that administration came in and re-checked everything to make sure staff complied and provided an in-service on elopements, abuse, and neglect. LVN V was sent home and informed that this was just part of the investigation process.</p> <p>During an interview on 12/12/24 at 10:16 AM, LVN E verbalized Resident #109 can read so she knows that the instructions on the door say to hold for 15 seconds, and it will open. LVN E, verbalized after the 10/27/24 elopement staff have been instructed to see who is at the door if the alarm goes off and do a head count of all the residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 12/12/24 at 10:28 AM, the DON verbalized she was not here the day Resident #109 eloped, but staff informed her of the elopement. DON voiced she is not sure if the resident walked through the grass around the back to reach the other end, or if she walked through the street that is located directly behind the building. DON acknowledged there was a potential for the resident to get hurt when she walked out of the memory care unit gate. DON verbalized that there were no other elopements since 10/27/24.</p> <p>During an interview on 12/12/24 at 11:12 AM the ADM verbalized that the videos show the resident leaving the facility at 10:33 AM but that the video was behind the regular time by one hour. ADM verbalized that the back cameras behind the building were not working.</p> <p>During an observation of the facility video footage on 12/12/2024, it reflected on 10/27/2024 resident exiting the alarm door outside the memory unit.</p> <p>During a telephone interview with Resident #109's family member on 12/12/24 at 1:24pm, she stated they called her about the elopement that she was in their outdoor patio and waited long enough that she stated that they did not tell her about the incident. Resident daughter verbalized she does not have any concerns about her being able to get out she is very normal, and a lot of people do not realize that she belongs there. Daughter verbalized if the resident does get out, she is not going to get hurt and not going to get far and stated with the nature of her disease it will happen from time to time.</p> <p>During an interview on 12/12/24 at 2:11 PM, maintenance employee W, stated that the alarms on the doors are checked monthly and records were provided and reviewed by survey team.</p> <p>During an interview on 12/12/24 at 2:15 PM, ADM verbalized that the back door was propped open for about 15 minutes on 10/27/24 after the residents were brought back into the building that morning. ADM verbalized she is trying to provide video footage, but it keeps freezing on her end.</p> <p>During an interview with DON on 12/12/24 at 3:02 PM, DON stated the nurse that was working on the 300-memory unit hall is was PRN nurse and 2 CNAs, along with an LVN and med aide. DON verbalized, I was not here that day, but I was told she walked outside the side door in front of the day room. The resident walked out the gate to the right, went out that door the blinds were closed in day room. Nurse went outside and she looked but the resident had closed the gate, so she just assumed that one of the residents pushed up on it. She was not gone that long at all. I will be honest less than 30 minutes. I will be honest the time stamp on the video footage is off. I believe when I calculated the time it was less than 30 minutes. Since then, we have done an in-service that includes staff need to make sure they are doing a roll count. Anytime alarms sound if it is not a planned exit, they need to make sure the residents are safe and all in the building. Make sure no doors are propped open. DON verbalized that all staff have been in-serviced and they were informed not to prop doors open, keep blinds open.</p> <p>During an interview on 12/12/24 at 3:15 PM, ADM voiced new policies and procedures to do roll call will, new wander guard ordered to be installed by 12/16/24 . They have increased staffing levels. Staff have dementia training that they must update monthly.</p> <p>During an interview on 12/12/24 at 3:48 PM with Alarm Representative X, the delayed egress should not be used for resident protection.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Schulenburg Regency Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  111 College St Schulenburg, TX 78956	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An observation of the outside of the back gate on 12/12/2024 at 11:00 AM where Resident #109 exited to the smoking gate where she was found by LVN H on 10/27/24 reflected approximately 200 - 225 feet of distance that the resident walked. There was a residential road directly behind the facility and a parking lot for employees to park.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 12/12/24. The Administrator was notified. The Administrator was provided with the IJ template on 12/12/24 at 3:30 PM.</p> <p>The following Plan of Removal submitted by the facility was accepted on 12/13/24 at 11:08 AM</p> <p>Plan of Removal</p> <p>Immediate Threat</p> <p>On 12/12/2024 an abbreviated survey was initiated at facility. On 12/12/2024 the surveyor provided an Immediate Jeopardy that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety.</p> <p>The notification of Immediate Jeopardy states as follows: state the issue you will find the info on the template you were provided.</p> <p>Action: 1:1 Monitoring; assess staff is required to be always within arm's reach of resident.</p> <p>Start Date: 12/12/2024 at 1:35 PM</p> <p>Completion Date: In progress, will not complete until additional hardware (wander guard is installed on 12/16/2024)</p> <p>Responsible: Facility's staffing nurse, the QM nurse, &amp; Director of Nursing is responsible for ensuring the adequate 1:1 Monitoring of resident.</p> <p>12-12-24 (Thursday): Staff #1 from 4 till left on bus.</p> <p>Staff #2- while on the bus</p> <p>12-12-24 (Thursday): staff # 3 from 8P-6A</p> <p>12-13-24 (Friday): staff #4 from 6A-6P</p> <p>12-13-24 (Friday): staff #3 from 6P-6A</p> <p>12-14-24 (Saturday): staff #5 from 6A-6P</p> <p>12-14-24 (Saturday): staff #6 from 6P-6A</p> <p>12-15-24 (Sunday): staff #4 from 6A-6P</p> <p>12-15-24 (Sunday): staff # 7 from 6P-6A</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>12-16-24 (Monday): staff # 4 from 6A-6P</p> <p>12-16-24 (Monday): staff # 8 from 6P-6A</p> <p>Action: Door Monitoring</p> <p>Start Date: 12/12/2024 6:00 PM.</p> <p>Completion Date: In progress until new locking mechanisms is installed, date pending.</p> <p>Responsible: Facility's staffing nurse, the QM nurse, &amp; Director of Nursing is responsible for ensuring the adequate 1:1 Monitoring of resident.</p> <p>12/12/24 7P- 6A Staff member #9</p> <p>12/13/23 6A-6P Staff member #10</p> <p>12/13/24 6P- 6A Staff member #10</p> <p>12./14/24 6A-6P Staff member #9</p> <p>12/14/24 6P- 6A Staff member #11</p> <p>12/15/24 6A-6P staff member #9</p> <p>12/15/24 6P- 6A staff member # 11</p> <p>12/16/24 6A-6P Staff member #12</p> <p>12/16/24 6P- 6A Staff member # 13</p> <p>Action: Training regarding: Abuse/Neglect, 1:1 Monitoring / Guarding of exit Doors, Elopement. A new policy and procedure , initiated on October 28, 2024, this procedure implements a roll call for all residents within the building. Medical Director, Director of Nursing, and Administrator created the policy and procedure 10/28/24. The CNAs receive training from charge nurses or administrative nurse, charge nurses are trained by the administrative nurses, who receive training from the DON, the DON receives training from Administrator; the Administrator receives training from Facility Consultant.</p> <p>Start Date: 12/12/2024.</p> <p>Completion Date: 12/13/2024</p> <p>Responsible: In-service was conducted by previous ADON on roll call 10/28/2024 &amp; again 12/12/2024 by IP and QM . Agency staff will receive in-services prior to their shift begins by the charge nurse on shift. Staff members who are off shift or PRN will receive in-service training via portal.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Action: Door Signage posted as a reminder to staff not to prop the door open. In-service training provided by QM to re-iterate that doors are not to be propped open at any time. The CNAs receive training from charge nurses or administrative nurse, charge nurses are trained by the administrative nurses, who receive training from the DON, the DON receives training from Administrator; the Administrator receives training from Facility Consultant .</p> <p>Start Date: 12/12/2024.</p> <p>Completion Date: 12/12/2024 6:30 PM</p> <p>Responsible: QM Admin Nurse</p> <p>Action: Elopement Assessments Completed monthly and Care plans Updated as needed. Findings will be reported monthly to QA committee for review, with changes made to the plan as required.</p> <p>Start Date: 12/12/2024 5:30 PM</p> <p>Completion Date: 12/12/2024 09:30</p> <p>Responsible: Assessments Charge Nurse #1, Care plans updated by designated MDS administrative nurse</p> <p>Action: The facility will conduct monthly audits to ensure that all assess</p> <p>Start Date: 12/12/2024 5:30 PM</p> <p>Completion Date: 12/12/2024 09:30</p> <p>Responsible: Assessments Charge Nurse #1, Care plans updated by designated MDS administrative nurse. QAPI attendees include Facility Consultant, Administrator, Medical Director, Director of Nursing, and all administrative nursing personnel. The Administrator receives training from facility consultant.</p> <p>The Survey Team monitored the Plan of Removal on 12/13/24:</p> <p>Observation on 12/13/2024 at 8:30 and 11:15am staff member sitting by the door .</p> <p>Observation on 12/13/2024 at 11:15am revealed a staff member was in arm reach of Resident #1 . Further observation revealed that door signage was posted on both doors .</p> <p>Observation on 12/13/2024 at 1:27pm revealed a staff member was sitting by the door .</p> <p>Observation on 12/13/2024 at 1:28pm revealed a staff member was in arm reach of Resident #1 .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an Interview on 12/13/2024 at 2:27 pm, LVN I stated and confirmed she took the training this month. LVN A stated that she was trained on one-on-one monitoring, Resident #109 is within arm's length and to always know the resident's location, and to keep the resident distracted. LVN, I stated she has been trained on monitoring the exit doors and she took all the training today. LVN, I stated when the alarm sounds, we must do a head count on all residents, monitor the doors, and keep them closed, do not leave them open. LVN, I stated she took the elopement training today, and to keep the door closed, perform head counts if the alarm goes off, and to always know the locations of all residents. LVN, I stated if a resident elopes, I must notify the ADM and DON, call 9-1-1, and to notify staff and attempt to locate the resident. LVN, I stated if the alarm goes off, I go to the location of the alarm, investigate what is going on, if I see a resident by the door I redirect the resident, I conduct a head count on the residents, and notify the ADM and DON. LVN I stated when completed the Charge nurse will ensure each resident is accounted for and after roll call, I keep a mental note of the findings and I then review our wander guard list and ADL list.</p> <p>During an interview on 12/13/2024 at 2:37 pm, CNA M stated she took the in-service yesterday (12/12/2024), she has been educated on resident rights, she has been in-serviced on one-on-one monitoring. CNA M stated the training covered on how not to leave the resident's (Resident #109) side, and that a staff must be always at their side. CNA M stated he has been trained on monitoring exit doors, and that if the alarm goes off, we look at the surrounding area and ensure no resident got out, we do a head count and we can reset the alarm. CNA M stated that she has been trained on elopement procedures and that if a resident elopes or even steps on the other side of the door we must intervene and report to the charge nurse on duty, the charge nurse then reports the elopement up the chain of command, the goal is ensure no residents eloped. CNA M stated if a resident attempts to elope we must act, we redirect the resident and have them come back inside, we make sure there are no other residents out, we immediately notify the charge nurse on duty and we do a head count. CNA M added that we (staff) are all responsible that each resident is accounted for, one of us goes down the hall, another staff goes to the day area, and a third staff check the other doors, and that after the roll call we notify the nurses where all the residents were located, and we make a mental note on the residents and we communicate with all staff to assure all residents are accounted for.</p> <p>During an interview on 12/13/2024 at 2:52 pm, CNA L stated she has been in-serviced on one-on-one monitoring on residents, and that we must keep residents safe, keep them from falling, assure residents are taken care of, and assure residents are within arm's reach. CNA L stated that she was trained on monitoring the exit doors and that she took the training today. CNA L stated the training covered the importance of watching and monitoring the doors, calling the ADM for all elopements, and the importance on all staff locating the residents. CNA L stated we immediately notify the charge nurse if a resident elopes, and if I hear an alarm I get up and check what set the alarm off; I see who went in our out, who is close to the door, I check outside to assure no residents are outside. CNA L stated that all staff are responsible for assuring each resident is accounted for, and that after roll call I confirm findings with nurse. CNA L stated that after our roll call we are checking all residents are accounted for, we are checking the number of residents locations and his or her ADL sheets.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 12/13/2024 at 2:58 pm, CNA K stated she has taken the training, she has been trained on one-on-one monitoring. CNA K stated that she was in-serviced on having the resident stay within arm's reach, and if the resident (Resident #109) attempts to leave outside we must redirect the resident and have them come back inside, we were educated on redirecting the resident, keeping the resident busy by communicating with the resident. CNA K stated she was in-serviced on monitoring the exit doors, and we cannot leave doors cracked or propped open, we cannot let residents leave unsupervised. CNA K stated she was trained on elopement procedures, CNA K added if I see a resident g out , I intervene, I notify the nurse on duty, I tell the charge nurse, I start looking for the residents, and we notify the ADM and DON. CNA K stated if an alarm goes off, I will run and investigate who is going out of the door, I investigate if it was a resident or if a resident is outside the door. CNA K stated all staff, the charge nurse, everyone is responsible on assuring all residents are accounted for, and that after we complete our roll call for residents we communicated with the nurse on findings. CNA K stated that during the roll call, we confirm all residents, we count and make sure all residents are here and we review the ADL sheet for the residents.</p> <p>During an interview on 12/13/2024 at 3:20 pm, LVN J she took trainings today, she has been trained on one-on-one monitoring and that we always have eyes on resident, within arm's reach, and if a staff member needs to go on break, we notify another staff to assure we are always doing these things. LVN J stated if an alarm goes off, we act, we do a head count, then a roll call to account all residents are here. LVN J confirmed she has taken the elopement trainings today, and added that if an alarm goes off, we act, the system will inform us what number band (wander guard) set off the alarm, and we follow the location of residents and roll call procedures. LVN J stated we must report all elopements to the DON, and if an alarm goes off, we find out if a resident went out of the building, we check outside the surrounding areas for any residents, and that we are all responsible that each and all residents are accounted for. After the roll call, I would take a mental note and recall each resident, if a resident is missing or not accounted for, I check our computer (records) and review who has been checked out (signed out on pass, appointment, et all) of the facility and reference that for all residents that should be present in the facility.</p> <p>During an interview on 12/13/2024 at 3:22 pm, DON stated training was completed today, on the importance of one-on-one monitoring, how residents must be within arms always reach and for staff to communicate if they need a break, staff must assure another staff takes over the important duties until they return. DON stated we had education on guarding or monitoring the doors today and that staff should be at the door 24/7 and that the elopement training was done this morning. DON stated the training covered what to do if there is an elopement; there needs to be a roll call and if it is in the secured unit, we need to do an elopement assessment to determine who is at risk of an elopement, we always respond to alarms or if a resident elopes. DON also stated if nursing staff will assure the roll calls are completed for the whole facility, I (DON) will notify ADM and do a self-reported incident to HHSC . DON stated staff are to respond immediately, to get our residents to safety, staff need to communicate and get in touch with the charge nurses to do a roll call of the entire facility, charge nurses will use a printed midnight census to assure all residents are in the building and after the roll call staff are to huddle, assure all is clear on resident head counts and locations and to report all findings to myself and ADM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 12/13/2024 at 3:29 pm, ADM stated we must report all findings of abuse, we have trained staff on one-on-one monitoring, we educated staff that one-on-one is defined as you (staff) stay within arm's reach of the resident that needs the monitoring and to communicate and call if they (staff) need a break so one-on-one can continue. ADM stated I have been trained on monitoring exit doors, and that guarding or monitoring the exit doors mean to redirect or ask for additional staff to assist with residents who are trying to enter or exit. ADM confirmed the elopement training education conducted today, this morning, that in the elopement training we check for resident's safety, staff must notify us, administration, the residents RPs and Doctors. ADM added that we placed interventions to keep our residents safe and from further elopement. ADM added we have been trained in an elopement situation staff are to perform if an alarm goes off, even if it is just a fire alarm, all residents must be accounted for, we look around the premises, we locate the residents, we call local law enforcement advise of a silver alert, we notify doctors or nurse practitioners, we were trained on the importance of a roll call being completed and that we can just clear or turn off the alarm, all residents must be accounted for prior to resetting any alarm. ADM stated that the charge nurses for each hallway are responsible for assuring the residents are accounted for by matching face to name on the midnight census, after the roll call this will be submitted to the nursing office.</p> <p>Record Review of In-Services for 1:1, door monitoring, door propping, elopement, abuse, and neglect, exit alarm sounding and Dementia revealed that 110 out of 129 staff have been in serviced. Staff interviews revealed staff have been trained on 1:1, door monitoring, exit door alarm, elopement, and roll call.</p> <p>Record reviewed revealed 110 out of 129 staff have been in-serviced on propping the door open .</p> <p>Record Review of all residents on memory care's medical records revealed that residents who were higher risk of elopement have been updated and their care plans h [TRUNCATED]</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872</b></p> <p>Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 medication storage rooms reviewed for medications.</p> <p>The facility failed to remove 2 expired suppositories and 1 bag of expired medication from the medication storage room when it was observed on 12/11/24 at 12:50 PM.</p> <p>This failure could place residents at an increased risk of receiving expired and/or contaminated medications which could result in adverse health consequences.</p> <p>Findings included:</p> <p>Observation on 12/11/24 at 12:50 PM in the medication storage room revealed 2 suppositories of bisacodyl 10 mg with expiration date 09/24 and one bag of Gentamicin 60 mg in 100 ml 0.9% sodium chloride for intravenous use with expiration date 12/6/24, belonging to Resident #36.</p> <p>Review of Resident #36's admission record dated 12/12/24 revealed an [AGE] year-old female, admitted on [DATE] with diagnoses that include urinary tract infection, traumatic brain injury, sick sinus syndrome (irregular heart rhythm), hyperlipidemia (high cholesterol), and Hypertension (high blood pressure).</p> <p>Review of Resident #36's readmission MDS assessment dated [DATE] revealed a BIMS score of 15 indicating no cognitive impairment.</p> <p>Review of Resident #36's physicians order summary dated 12/12/24 revealed an order for Gentamicin Sulfate Injection Solution 40 mg/ml. Use 60mg intravenously at bedtime related to bacteremia (an infection in the blood) for 5 days. Status on hold. Start date 12/2/24. End date 12/7/24.</p> <p>Review of Resident #36's care plan dated 12/2/24 revealed Urinary tract infection; at risk for repeat urinary tract infections. Goal: Resident will show no signs/symptoms of infection. Interventions/Tasks: Administer antibiotic therapy as prescribed.</p> <p>In an interview on 12/11/24 at 12:50 PM LVN F stated she had been working in the facility since January 2021. She stated nurses and medication aides are responsible for checking for expiration dates. LVN F stated that medications could lose effectiveness over time and may not work as well if administered to a resident.</p> <p>In an interview on 12/12/24 at 9:27 AM LVN E stated she had been working in the facility since [DATE]. She stated that nurses, medication aides, and administration should check for expired medications at least once a month. LVN E stated the expired medications would not be as effective if given to a resident.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/12/24 at 1:20 PM LVN G stated she had been working in the facility since August 2022. She stated that nurses should check for expired medications. LVN G stated the expired medications would not be as effective if given to a resident. She stated that the medication that was expired for Resident #36 was because the resident had a lab level drawn to check for the antibiotic in the resident's blood. She stated that the level was too high and so the medication was held and not used.</p> <p>In an interview on 12/12/24 at 02:39 PM the DON stated she had been working at the facility since March 2021. She stated she expected the pharmacy consultant to check the medication room and carts monthly, and the nurses and medication aides to check at least weekly. The DON stated that using medications after they have expired could lead to decreased effectiveness or a possible adverse reaction.</p> <p>In an interview on 12/12/24 at 3:04 PM the ADM stated her expectation was for the nurses and medication aides to check the medication carts and room weekly on Sunday nights and for administration to check the carts/room monthly for expired medication. The ADM stated using the medication after the expiration date could lead to decreased effectiveness.</p> <p>Review of an undated facility policy and procedure titled Storage of Medications reflected The facility will store all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.</p>