STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455959	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westward Trails Nursing and Rehabilitation	3001 Westward Dr Nacogdoches, TX 75964

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on interview, and record review the facility failed to ensure residents the right to be free from abuse and neglect for 1 of 6 (Resident #4) residents reviewed for abuse and neglect. The facility failed to ensure Resident #4 was free from verbal abuse from Resident #3 on 10/31/2024 during a resident to resident verbal altercation. These deficient practices could place residents at risk for abuse, neglect, and not having their needs met. Findings included: 1.Record review of Resident #4's electronic face sheet revealed a [AGE] year-old-female who was admitted to the facility on [DATE] with most recent admission on 2/24/2024. Resident #4's diagnoses included: nontraumatic subarachnoid hemorrhage (bleeding in the brain), seizures (disruption of normal brain function), and muscle weakness. Record review of Resident #4's Quarterly MDS, dated [DATE] indicated a BIMS of 03 indicating a severe cognitive impairment. The MDS indicated Resident #4 was dependent for all bed mobility. Record Review of Resident #4's care plan dated 12/7/2021 and revised on 2/5/2024 indicated: Resident #4 had a communication problem related to cerebrovascular accident causing aphasia, dysphagia and cognitive deficit with interventions that included: Use effective strategies: facial expression, eye contact, gestures, tone of voice, non-threatening posture, short direct phrases, speak slowly, speak in a calm, distinct manner, interpreter, time to communicate, 1 to 1, quiet setting for communicating with resident. 2.Record review of facility electronic face sheet indicated Resident #3 was a [AGE] year-old female admitted to facility on 5/01/2024 with the most recent admission on 11/05/2024. Resident #3's diagnosis included: dementia (decline in mental ability), anxiety (excessive worry, fear, and nervousness), and bipolar disorder (extreme shifts in mood, energy, and behavior). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #3's comprehensive care plan dated 1/08/2025 indicated Resident # 3 refused medications at times with intervention of a negotiated risk assessment signed. Resident #3 had impaired cognitive function dementia or impaired thought processes with an intervention to administer medications as ordered. Resident #3 had verbal behaviors threatening to kill roommate and staff with an intervention of assist resident in avoiding resident that may incite outburst. Resident #3 required antipsychotic medications with an intervention to administer medications as ordered, monitor and document for side effects and effectiveness. Record review of Resident #3's Quarterly MDS dated [DATE] indicated Resident #3 had a BIMS of 15 indicating no cognitive impairment. Record review of nursing progress note dated 10/31/2025 at 4:15 AM written by RN D indicated: I heard resident screaming at nurse aide that if she touches her, she will kill her. I entered the room and resident sitting [Resident #4's] bed and cursing. I called the aide to the side, and she stated that she was trying to get [Resident #3] to get off the bed, as she was threatening her too. I witnessed then [Resident #3] threaten to hit the other resident, and to even kill her if she touched her. I asked [Resident #3] what is wrong, did she need me to send her to the hospital. She said no. Interventions: I talked with [Resident #3] and convinced her to get into her own bed. She started to cry, got up and got into her bed and covered her head . During an interview on 3/25/2025 at 1:05 PM LVN E said Resident #3 had a psychotic episode on 10/31/2025 at 4:15 AM. She said RN D went to Resident #3's room and during the psychotic episode found Resident #3 on top of Resident #4 threatening to kill her. She said RN D was able to de-escalate the situation and moved Resident #4 out of the room. During an interview on 3/25/2025 at 3:00 PM the DON said on 10/31/2024 Resident #3 was found sitting on Resident #4's bed threatening to kill her. She said Resident #4 was removed from the room and did not have any effects from the incident due to Resident #4's cognition. During an interview on 3/26/2025 at 10:49 AM RN D said on 10/31/2025 at about 4:15 AM she went down the hall and heard resident screaming so she went in the room and the aide was in the room and Resident #3 was sitting on Resident #4's bed shaking her fist threatening to kill Resident #4. She said she removed Resident #4 from the room and took her to the dining room. She said she tried to call the DON with no answer, so she notified the on-call nurse of the situation. During an interview on 3/26/2025 at 11:21 AM RN G said she was on call the night of 10/31/2024 and received a call from RN D regarding Resident #3 having a psychotic episode. She said she told RN D to make sure that Resident #4 was out of the room and safe. During an interview on 3/26/2025 at 1:19 PM CNA H said on the night of 10/31/2025 she remembered Resident #3 was not herself that night. She said Resident #3 was getting up and going over to Resident #4's side of the room. She said Resident #4 was bedbound and Resident #3 was sitting on the edge of Resident #4's bed threatening to kill her. She said she told Resident #3 she couldn't be on Resident #4's bed and that's when she became combative to the CNA. She said RN D entered the room and was finally able to calm Resident #3 down enough to get her off Resident #4's bed and back in her own bed. She said Resident #4 was then removed from the room. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 2:45 PM the DON said the reason it was not reported was because Resident #3 had a psychotic issue but never did anything to Resident #4. She said that Resident #4 did not appear to be upset and she did not feel as though the incident was reportable. She said they did not feel as though it was abuse because it did not harm Resident #4 physically or emotionally. She said she knew they talked about the situation in the morning meeting the next day. So, it was at least by the morning meeting that the Administrator was notified. She said the expectation was that all allegations of alleged abuse be reported to the abuse coordinator immediately. During an interview on 3/26/2025 at 2:55 PM the Administrator said they did not report that incident because Resident #4 did not even know what was going on. He said when they separated Resident #3 and Resident #4 there was no injury to Resident #4. He said his expectation was they will follow their policy and guidelines for reporting alleged abuse. Record review of facility policy titled Abuse/Neglect dated 3/29/18 indicated: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in the subpart . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility . 3. Verbal Abuse: Any use of oral , written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again, etc. Abuse as defined in 40 TAC 19.101(1) . E. Reporting .3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19 .

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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	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** 47339 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (which included to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 of 6 residents (Resident #4 and Resident # 3) reviewed for abuse. The facility failed to keep Resident #4 safe from verbal abuse from Resident #3. On 10/31/2025 at 4:15 AM Resident #4's roommate was found on Resident #3 's bed threatening to kill her. This failure could place residents at risk of further potential abuse. Findings included: 1.Record review of Resident #4's electronic face sheet revealed an [AGE] year-old-female who was admitted to the facility on [DATE] with most recent admission on 2/24/2024. Resident #4's diagnoses included: nontraumatic subarachnoid hemorrhage (bleeding in the brain), seizures (disruption of normal brain function), and muscle weakness. Record review of Resident #4's Quarterly MDS, dated [DATE] indicated a BIMS of 03 indicating a severe cognitive impairment. The MDS indicated Resident #4 was dependent for all bed mobility. Record Review of Resident #4's care plan dated 12/7/2021 and revised on 2/5/2024 indicated: Resident #4 had a communication problem related to cerebrovascular accident causing aphasia(affects the ability to communicate), dysphagia (difficulty swallowing) and cognitive deficit with interventions that included: Use effective strategies: facial expression, eye contact, gestures, tone of voice, non-threatening posture, short direct phrases, speak slowly, speak in a calm, distinct manner, interpreter, time to communicate, 1 to 1, quiet setting for communicating with resident. 2.Record review of facility electronic face sheet indicated Resident #3 was a [AGE] year-old female admitted to facility on 5/01/2024 with the most recent admission on 11/05/2024. Resident #3's diagnosis included: dementia (decline in mental ability), anxiety (excessive worry, fear, and nervousness), and bipolar disorder (extreme shifts in mood, energy, and behavior). Record Review of Resident #3's comprehensive care plan dated 1/08/2025 indicated Resident # 3 refused medications at times with intervention of a negotiated risk assessment signed. Resident #3 had impaired cognitive function dementia or impaired thought processes with a intervention to administer medications as ordered. Resident #3 had verbal behaviors threatening to kill roommate and staff with an intervention of assist resident in avoiding resident that may incite outburst. Resident #3 required antipsychotic medications with an intervention to administer medications as ordered, monitor and document for side effects and effectiveness. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Quarterly MDS dated [DATE] indicated Resident #3 had a BIMS of 15 indicating no cognitive impairment. Record review of nursing progress note dated 10/31/2025 at 4:15 AM written by RN D indicated: I heard resident screaming at nurse aide that if she touches her she will kill her. I entered the room and resident sitting [Resident #4's] bed and cursing. I called the aide to the side and she stated that she was trying to get [Resident #3] to get off the bed, as she was threatening her too. I witnessed then [Resident #3] threaten to hit the other resident, and to even kill her if she touched her. I asked [Resident #3] what is wrong, did she need me to send her to the hospital. She said no. Interventions: I talked with [Resident #3] and convinced her to get into her own bed. She started to cry, got up and got into her bed and covered her head . During an interview on 3/25/2025 at 11:00 AM Resident #4 was not able to answer questions appropriately due to cognition. During an interview on 3/25/2025 at 1:05 PM LVN E said Resident #3 had a psychotic episode on 10/31/2025 at 4:15 AM. She said RN D went to Resident #3's room and during the psychotic episode found Resident #3 on top of Resident #4 threatening to kill her. She said RN D was able to de-escalate the situation and moved Resident #4 out of the room. During an interview on 3/25/2025 at 3:00 PM the DON said on 10/31/2024 Resident #3 was found sitting on Resident #4's bed threatening to kill her. She said Resident #4 was removed from the room and did not have any effects from the incident due to Resident #4's cognition. Resident #3 was monitored 1 to 1 until she discharged to the hospital. During an interview on 3/26/2025 at 10:49 AM RN D said on 10/31/2025 at about 4:15 AM she went down the hall and heard resident screaming so she went in the room and the aide was in the room and Resident #3 was sitting on Resident #4's bed shaking her fist threatening to kill Resident #4. She said she removed Resident #4 from the room and took her to the dining room. She said she tried to call the DON with no answer, so she notified the on-call nurse of the situation. During an interview on 3/26/2025 at 11:21 AM RN G said she was on call the night of 10/31/2024 and received a call from RN D regarding Resident #3 having a psychotic episode. She said she told RN D to make sure that Resident #4 was out of the room and safe. During an interview on 3/26/2025 at 1:19 PM CNA H said on the night of 10/31/2025 she remembered Resident #3 was not herself that night. She said Resident #3 was getting up and going over to Resident #4's side of the room. She said Resident #4 was bedbound and Resident #3 was sitting on the edge of Resident #4's bed threatening to kill her. She said she told Resident #3 she couldn't be on Resident #4's bed and that's when she became combative to the CNA. She said RN D entered the room and was finally able to calm Resident #3 down enough to get her off Resident #4's bed and back in her own bed. She said Resident #4 was then removed from the room. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 2:45 PM the DON said the reason it was not reported is because Resident #3 had a psychotic issue but never did anything to Resident #4. She said that Resident #4 did not appear to be upset and she did not feel as though the incident was reportable. She said they did not feel as though it was abuse because it did not harm Resident #4 physically or emotionally. She said she knew they talked about the situation in the morning meeting the next day. So, it was at least by the morning meeting that the Administrator was notified. She said the expectation was that all allegations of alleged abuse be reported to the abuse coordinator immediately. During an interview on 3/26/2025 at 2:55 PM the Administrator said they did not report that incident because Resident #4 did not even know what was going on. He said when they separated Resident #3 and Resident #4 there was no injury to Resident #4. He said his expectation is they will follow their policy and guidelines for reporting alleged abuse. Record review of facility policy titled Abuse/Neglect dated 3/29/18 indicated: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in the subpart . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility . 3. Verbal Abuse: Any use of oral , written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again, etc. Abuse as defined in 40 TAC 19.101(1) . E. Reporting .3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19 .

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards and each resident received adequate supervision as is possible for 2 of 6 resident (Resident #1 and Resident #2) reviewed for accidents and hazards. 1.The facility failed to ensure Resident #1 did not wander outside of the facility and down the road while wearing a wander guard. On 1/04/2025 Resident #1 while wearing a wander guard left the facility through the front door and was seen walking down the road by another resident's family member who notified the facility of Resident #1's whereabouts. The non-compliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began 01/04/2025 and ended on 01/08/2025. The facility corrected the non-compliance before surveyor's entrance. 2.The facility failed to ensure Resident #2 was properly strapped down in the van to prevent Resident #2's wheelchair from flipping over backwards during transport. On 2/21/2025 during transport to dialysis by the contract transport service Resident #2's wheelchair flipped over backwards in the van causing Resident #2 to have head and neck pain. The non-compliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began 02/21/2025 and ended on 02/25/2025. The facility corrected the non-compliance before surveyor's entrance. This failure could place residents at risk of harm and serious injuries due to lack of supervision and failure to follow protocols. Findings included: Record review Resident #1's Face sheet dated 3/25/2025 indicated Resident #1 was admitted to the facility on [DATE] with the most recent admission on 12/04/2023. Resident #1 was a [AGE] year-old female admitted with diagnosis of severe dementia with anxiety (agitation, restlessness, and difficulty concentrating stemming from confusion and disorientation), hypertension (high blood pressure), and muscle weakness. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 04 indicating severe cognitive impairment. The MDS Assessment indicated Resident #1 required supervision or touching assistance with walking 150 feet. Record review of Resident#1's care plan dated 11/04/2021 indicated: Resident #1 was at risk for wandering, Resident #1 had a wander guard in place with interventions that included: .3. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. 4. Identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. 5. If the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's medication administration record dated January 2025 indicated: Monitor for function of wander guard every shift and as needed for preventative and was signed as functioning on 1/3/2025 night shift. Record review of Resident #1's weekly skin assessment dated [DATE] indicated Resident #1 did not have any skin issues. Record review of Resident #1's elopement risk assessment dated [DATE] indicated a score of 9 which indicated low risk for elopement. Record review of incident report dated 01/04/2025 revealed: elopement on 1/04/2025 at 9:10am from the reception/lobby. No injuries were observed at the time of the incident and Resident #1 was not taken to the hospital. Record review of the facility's Provider Investigation report dated 01/09/2025 revealed the following: The resident went out the front door and was observed by another family member about 60 yards away from the facility. They notified the facility, and the resident was returned with no injuries. During an observation on 3/25/2025 at 3:00 PM the Administrator and DON demonstrated Resident #1's wander guard at the front door and the door did not alarm or lock. The Corporate Maintenance Director provided a new wander guard and when approached at the front door the door locked, when the new wander guard approached the front door when the door was open, and alarm sounded. During an interview on 3/25/2025 at 3:00 PM the DON said Resident #1 went out the front door of the facility. She said Resident #1's wander guard did not lock the front door or alarm. The DON said the wander guard had been checked on the night shift prior to the morning of the incident and said it was functioning. She said after the incident and Resident #1 was returned to the facility the malfunctioning wander guard was replaced with a new one and Resident #1 was placed on 1 to 1 supervision. She said Resident #1 was discharged later that day to a facility with a secured unit. During an interview on 3/25/2025 at 3:00 PM the Administrator said the Resident #1's wander guard did not lock the front door or alarm. He said sometime between it being checked on the night shift and the incident the wander guard malfunctioned and did not work. He said another resident's family member took a picture of the resident walking down the road and showed it to the facility and the facility went and retrieved Resident #1 without incident. Resident #1 was returned to the facility and a new wander guard was placed on Resident #1. He said a head-to-toe assessment was completed on Resident #1 with no injuries found. He said later that same day the resident was transferred to another facility with a secured unit. Record review of QAPI notes dated 01/04/2025 indicated that the meeting was attended by the following members: Administrator, DON, ADON, Medical Director, Social Services, Dietary, MDS Nurse, Activity Director, Therapy, and Medical Records. The interventions and plan for correction included: 1. Self report to HHSC. 2. Interview the resident completed on 1/4/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Take statements from everyone involved or with potential knowledge/involvement completed 1/4/2025. 4. Determine if resident will be able to remain in the facility with any new interventions. Resident #1 was transferred to a new facility with a secured unit on 1/4/2025. 5. 1 on 1 monitoring for resident involved until evaluated by the IDT and further instructions are provided. Completed on 1/4/2025. 6. Complete risk management entry for elopement and complete elopement event note and elopement risk assessment for the resident involved. Document conclusion in the risk management entry of PCC (records system). Completed on 1/4/2025. 7. Complete an elopement risk assessment for all other residents. Completed 1/4/2025. 8. Complete the QA tool for elopements. Completed 2/4/2025. 9. Update the care plan for the resident who exited with new interventions. Completed 1/4/2025. 10. Review and update the plan of care as needed of any resident who has been assessed to be a high risk for elopement. Completed 1/4/2025. 11. Perform trauma informed PRN assessment on affected resident and initiate/update care plan interventions as needed. Completed 1/4/2025. 12. If known, in-service staff related to findings and ways to prevent residents exiting. In-services on abuse, neglect, and elopement initiated on 1/4/2025. 13. Notification to families to mindful of residents attempting to exit the facility and not to share the door code with the residents. Completed on 1/10/2025. 14. Place signage at visitor exits to be mindful of residents attempting to exit the facility and not to share a door code with the residents. Completed 1/4/2025. 15. The Medical Director was notified of this plan. Completed 1/4/2025. Record review of Resident #1's electronic medical record indicated Resident #1 discharged from the facility on 1/4/2025. Record review of 1 to 1 monitoring sheets dated 1/4/2025 from 9:30 AM to 3:45 PM. Record review of Missing Resident/Elopement Monitoring tool dated 1/4/2025 through 2/4/2025 indicated: 1. The locking mechanism or alarm functioned properly on all exit doors of the facility. 2. Wander guard bracelets were in place every shift. Record review of Trauma Informed PRN assessment dated [DATE] indicated Resident #1 had no trauma from the incident. (continued on next page)

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Westward Trails Nursing and Rehabilitation	3001 Westward Dr Nacogdoches, TX 75964

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Elopement Risk assessment dated [DATE] indicated a score of 28 which indicated high risk for elopement. Record review of the care plan for Resident #1 indicated revised on 1/4/2025 indicated a new intervention for 1 to 1 monitoring of Resident #1 until alternate placement could be arranged. Record review of in-services dated 1/4/2025-1/5/2025 titled Abuse, Neglect, Elopement, ways to prevent resident exiting, reporting concerns with 135 employee signatures. Record review of elopement drills dated 1/7/2025, 1/9/2025, 1/15/2025, 1/17/2025, 1/21/2025, and 1/23/2025 indicated multiple drills across multiple shifts had been conducted. Observation of signage on the front door of the facility on 3/25/2025 at 3:00 PM notifying families to be mindful of residents attempting to exit the facility and not to share door code with the residents. On 3/25/25 at 10:51 am the Administrator, and DON were informed of IJ. The non-compliance was identified as past non-compliance. The IJ began on 1/04/2025 and ended on 2/4/2025. The facility had corrected the noncompliance before the investigation began. 2. Record review of the electronic face sheet dated 3/24/2025 for Resident #2 indicated Resident #2 was admitted to the facility on [DATE] with diagnosis that included: end stage renal disease (kidneys do not function properly), hyperkalemia (excessive amount of potassium in the blood), and muscle weakness. Record review of Resident #2's quarterly MDS dated [DATE] indicated Resident #2 had a BIMS score of 11 which indicated mild cognitive impairment. The MDS assessment indicated Resident #2 required supervision or touching assistance for transfers. Record review of Resident #2's care plan dated 9/22/2023 and revised on 2/5/2024 indicated Resident #2 had end stage renal disease and was on dialysis on Mondays, Wednesdays, and Fridays with interventions that included: 1. Encourage resident to do for the scheduled dialysis appointments, resident received dialysis on Mondays, Wednesdays, and Fridays. The resident had an ADL self-care performance deficit with interventions that included: 1. the resident uses a wheelchair. The resident was at risk for falls gait/balance problems with interventions that included: 1. Skin assessment, new pain medication, xrays ordered, neuros started, 3rd party transportation on hold for in-servicing their staff on van safety/buckling and monitoring in place. Record review of nursing progress note dated 2/21/2025 at 6:00 AM written by LVN C indicated Notified by transport driver, while on the way to drop off resident at dialysis, residents wheelchair tilted backwards resulting in resident falling backwards in chair. Driver states resident stated he was ok to continue to dialysis appointment. Record review of nursing progress note dated 2/21/2025 at 10:30 AM written by LVN C indicated Resident returned from dialysis and is complaining of neck pain post fall from this morning. New order received for xray of neck due to neck pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of nursing progress note dated 2/21/2025 at 10:30 AM written by the DON indicated Resident denied any pain medication at this time and stated he would let us know if he needed anything. Record review of nursing progress note dated 2/21/2025 at 11:40 AM written by the DON indicated Down to check on resident at this time to see how he is doing; resident is stating that his head/neck is bothering him and asked if he could get something for pain at this time. MD was notified and new order for Tylenol 325mg every 4 hours as needed for pain. (medication was administered at this time to resident) Attempted to notify [family] but no answer at this time. Record review of nursing progress note dated 2/21/2025 at 12:03 PM written by the DON indicated Down to follow up with resident and he does state that the Tylenol was effective. Record review of nursing progress note dated 2/21/2025 at 1:46 PM written by the DON indicated Went down to check on resident at this time and he stated that he was feeling ok. Inquired again if resident was wanting to go to ER (resident had been asked when incident initially occurred if he would like to go be he did not feel he needed to go at that time and wanted to proceed going to dialysis) to get checked out and he stated well I feel like I guess I should. Explained that xrays had been taken and results were pending when I last looked however if felt he needed to be checked out we could certainly send him. He thought for a minute and stated he felt like he ought to go ahead and go just to be safe. MD notified of request and new orders given to transport to ER for evaluation and treatment. Record review of nursing progress noted dated 2/21/2025 at 5:42 PM written by ADON B indicated Resident returned via wheelchair with [facility] van transport from [hospital] ER related to fall, resident cleared from ER and sent back to facility with no changes in medications or orders. Record review of facility incident report dated 2/21/2025 at 6:00 AM indicated Resident #2 had a fall with no other information. Record review of hospital paperwork dated 2/21/2025 indicated no acute findings and Resident #2 was discharged back to the facility with no new orders. During an interview on 3/24/2025 at 10:33 AM Resident #2 said on the day he fell in the van the Contract Van Driver did not strap him down in the van. He said the Contract Van Driver was trying to go up the hill in the driveway and his wheelchair flipped backwards. He said the Contract Van Driver stopped and picked him back up in the van. He said he told the Contract Van Driver he was having pain but the Contract Van Driver continued on to dialysis. He said he told them at dialysis he was in pain also. He said when he got back to the facility the nurse checked him over and he complained of head and neck pain. He said the facility sent him out to the ER to get checked out. He said he no longer is having any pain to his head and neck. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/24/2025 at 11:10 AM the Contract Van Driver said on 2/21/2025 at approximately 5:00 AM he got to the facility and put the resident on the van. He said he placed Resident #2 on the ramp and raised the ramp. He said he then pushed Resident #2 forward, he said he usually used 2 front straps, and 2 back straps when securing a resident in the van. He said when he drove off and going up the incline in the facility parking lot Resident #2 flipped back in his wheelchair. He said he stopped the van and got out to check if Resident #2 was ok, and said Resident #2 told him that he was fine and to continue on to dialysis. He said he picked Resident #2 upright in his wheelchair and continued on to dialysis. He said he did not notify anyone of the fall until later on that day. He said he had no idea how the incident happened. During an interview on 3/24/2025 at 11:30 AM the Facility Van Driver said she picked up Resident #2 from dialysis on the day he fell on the Contract Van. She said when she picked him up about 10:30am the Dialysis Tech pushed him out to the van that day and said Resident #2 was complaining of severe head and neck pain because he fell backwards in the Contract Van that morning. She said she brought Resident #2 straight back to the facility and said when she got there the Contract Van Driver was at the facility to report the fall that happened that morning. Said she reported to the nurse that Resident #2 was complaining of head and neck pain. She said to properly secure a resident's wheelchair in the van there should be 2 tie down straps at the front of the wheelchair and 2 tie down straps at the back of the wheelchair, she said then there is a seatbelt that goes across the resident to hold the resident in the chair. She said if all straps are applied appropriately there would be no way a resident's wheelchair could flip over backwards. During an interview on 3/24/2025 at 12:26 PM the Dialysis Tech said on 2/21/2025 Resident #2 never complained of pain until the end of his treatment and then he told her that he had fallen in the van on his way to dialysis that morning. She said she did not administer anything for pain while he was at dialysis that day. She said the Contract Van Driver did not notify anyone at dialysis that Resident #2 had fallen that morning. During an Observation and interview on 3/24/2025 at 12:43 PM the Contract Van Driver demonstrated how to correctly strap down a wheelchair in the van. At the end of the demonstration the surveyor asked the Contract Van Driver if it was plausible that on the day Resident #2 fell in the van that Resident #2 was not secured properly in the van and the Contract Van Driver said yes. During an interview on 3/25/2025 at 10:25 AM the Corporate Maintenance Director said to properly secure a resident's wheelchair in the van there should be 2 tie down straps at the front of the wheelchair and 2 tie down straps at the back of the wheelchair, he said then there is a seatbelt that goes across the resident to hold the resident in the wheelchair. He said if all straps are applied appropriately there would be no way a resident's wheelchair could flip over backwards and the wheelchair should not move in the van. During an interview on 3/25/2025 at 10:40 AM the DON said on 2/21/2025 at approximately 10:30 AM the Contract Van Driver came to the facility to report to her that Resident #2 had fallen in the van that morning. She said the Contract Van Driver did not report it to the facility that morning when it happened but waited until later in the day. She said the Contract Van Driver told her he asked Resident #2 if he was ok and Resident #2 said he was, so he continued with transporting Resident #2 to dialysis. She said the Contract Van driver said he had not reported the incident to dialysis. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/25/2025 at 11:04 AM the Administrator said on 2/21/2025 he received a call from the Contract Van Drivers supervisor stating the Contract Van Driver was going to the facility to let them know about and incident that had happened that morning. He said at approximately 10:30 AM he overheard the Contract Van Driver telling the DON that Resident #2 had fallen in the van that morning. He said the Contract Van Driver said he loaded Resident #2 on the van and when leaving the facility parking lot incline Resident #2 flipped backwards in his wheelchair. He said the Contract Van Driver immediately stopped the vehicle and asked Resident #2 if he was ok and Resident #2 said lets just go on to dialysis. He said Resident #2 denied any pain, so he continued transport to dialysis. Record review of Contract Van Drivers successful completion of the Passenger Assistance Safety and Sensitivity 7.0 Two-day Driver Certification Program including sensitivity training, left operating procedures, wheelchair and occupant securement valid January 09, 2025, through January 09, 2027. Observation of training video titled Retractable wheelchair tie-downs to secure wheelchair superior van and mobility. Video was accessed at https://youtu.be/mY_GThwGdbI?si=zQH-3ntbRIcPyck0 which indicated there should be 2 tie down straps in the front of the wheel chair and 2 tie down straps at the back of the wheelchair and the seatbelt that goes across the resident. Surveyor requested the facility policy and procedure regarding wheelchair tie down procedure and none was provided. Record review of QAPI notes dated 02/21/2025 indicated that the meeting was attended by the following members: Administrator, DON, ADON, Medical Director, Social Services, Dietary, MDS Nurse, Activity Director, Therapy, and Medical Records. The interventions and plan for correction included: 1. Self report to HHSC. Completed 2/21/2025. 2. The Contract van services was removed from service for resident transport on 2/21/2025. 3. The Contract Van Services were to educate drivers before services to be reinstated. Completed on 2/25/2025. 4. The Contract Van Driver was not allowed to transport for the facility pending investigation. Completed 2/21/2025. 5. Take statements from everyone involved or with potential knowledge/involvement. Completed 2/21/2025. 6. Begin abuse/neglect in-service for all staff who transport or assist with transporting residents in the van. Started on 2/21/2025. 7. In-service staff who transport or assist with transporting residents in the van on the following (with return demonstration): How to safely load and unload residents in the van using the lift, properly securing a resident in the van, ambulatory resident -securing with a seatbelt, Non-ambulatory resident-securing the wheel chair and the resident. Started 2/21/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of resident safe surveys on abuse/neglect completed on 2/21/2025 with no concerns noted. Record review of monitoring of the Facility Van Driver completed 2/21/2025 through 2/27/2025 with no concerns noted. On 3/25/25 at 10:51 am the Administrator, and DON were informed of IJ. The non-compliance was identified as past non-compliance. The IJ began on 2/21/2025 and ended on 2/25/2025. The facility had corrected the noncompliance before the investigation began.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50071 Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, as based on the comprehensive assessment of the residents; in that: 4 out of 5 residents reviewed incontinence (Resident #5, #6, #7, #8) The facility failed to ensure Residents #5, #6, #7, and #8 were not wearing two briefs after incontinent care was provided. Residents #5, #6, #7, and #8 were observed wearing two briefs at the same time. These deficient practices could place residents at-risk for infections and skin break downs due to improper care practices. The findings included: Record review of a facility face sheet dated 3/26/25 for Resident #6 indicated she was a [AGE] year-old female admitted to the facility 4/6/2022 with diagnoses including Seizures, Morbid Obesity, and Pressure Ulcer. Record review of a Comprehensive MDS assessment dated [DATE] for Resident #6 revealed a BIMS score of 11, indicating moderate cognitive impairment. She required maximal assistance with all ADLs, and she was incontinent to bowel and bladder. Record review of a care plan dated 3/26/25 for Resident #6 indicated potential/actual impairment to skin integrity related to immobility and Obesity. Record review of a comprehensive care plan dated 3/26/25 for Resident #6 indicated impaired cognitive function/dementia or impaired thought processes related to diagnosis of Alzheimer's. Record review of a facility face sheet dated 1/01/2024 for Resident #5 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including cerebral vascular accident (stroke), pneumonia, pressure ulcer to the head and urinary tract infection. Record review of a Comprehensive MDS assessment dated [DATE] for Resident #5 revealing a BIMS score of 13, indicating intact cognitive functioning. She required maximal assistance with all ADLs, and incontinent to bowel and bladder. Record review of a comprehensive care plan dated 1/01/2024 for Resident #5 indicated he was dependent on staff for immobility, physical limitations, and social interactions. Record review of a facility face sheet dated 3/26/25 for Resident #8 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Type-2 Diabetes mellitus, foot ulcer, hypertension, cerebral infraction (Stroke). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Comprehensive MDS assessment dated [DATE] for Resident #8 revealed a BIMS score of 10, indicating moderate cognitive impairment. She required maximal assistance with all ADLs and was incontinent to bowel and bladder. Record review of a comprehensive care plan dated 3/26/25 for Resident #8 indicated potential/actual impairment to skin integrity. Record review of a comprehensive care plan dated 3/26/25 for Resident #8 indicated had impaired cognitive function/dementia or impaired thought processes neurological symptoms with cardiovascular accident. Record review of a facility face sheet dated 3/27/25 for Resident #7 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Type-2 Diabetes mellitus, foot ulcer, hypertension, cerebral infraction. Record review of a Comprehensive MDS assessment dated [DATE] for Resident #7 revealed a BIMS score of 10, indicating moderate cognitive impairment. He required maximal assistance with all ADLs, and he was incontinent to bowel and bladder. Record review of a comprehensive care plan dated 3/27/25 for Resident #7 indicated the potential for further pressure ulcer development and worsening of current pressure ulcer with cognitive deficits, physical limitations, and fragile skin. Record review of a comprehensive care plan dated 3/27/25 for Resident #7 indicated he had impaired cognitive function/dementia or impaired thought processes dementia. During an interview and observation on 3/25/2025 10:50am with Resident #6 she said she had on two briefs and wears 2 brief every day. She said she did not ask to be doubled briefed but had not complained about it because she felt it helped her not soil her bed. She said she did not get changed every two hours and sometimes it was more than 3 hours Resident #6 was observed with two briefs at that time. During an interview and observation on 3/25/2025 11:10am with Resident #8 he said he wears 2 briefs at one time every day and night. He said he did not ask for the briefs and not remember staff asking him if he wants the briefs or not. Resident #8 was observed with two briefs at that time. During an interview and observation on 3/25/2025 11:30am with Resident #7 he said he wear briefs and do not know how many they put on but thinks they put on two briefs each time they change him. Resident #7 was observed with two briefs at that time. During an interview and observation on 3/25/2025 11:45am with Resident #5 he said he know he wears briefs but do not know how many briefs he has on and never asked anyone. Resident #5 was observed with two briefs at that time. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/2025 at 1:11pm CNA K she said she do not know about any resident being double briefed and she as well as other CNA's use single briefs daily on several of the incontinent residents. She said she was not sure of the number of residents that use briefs in the facility. She said that's the way it was done when she started work at the facility, and she just continued with the resident's normal daily care. She said they have frequent in-services on abuse/neglect, incontinent care, residents' rights, and other direct care trainings. During an interview on 3/24/2025 at 3:25pm CNA I she said she uses briefs on some residents but do not use two at one time. She said she have witnessed double briefing a couple of times in the past but not lately and do not know who applied the double briefs. She said she know that double briefing is wrong and not sure of the negative effects but knows to only use one brief at a time. During an interview on 3/24/2025 at 2:14pm with CNA J she said she have witness aides doubled briefing residents. She said she reported to the charge nurses when she found double briefing. She said double briefing or leaving briefs on too long could cause skin break downs and irritation to residents. During an interview on 3/24/2025 at 2:45pm with LVN L she said she have not witnessed any residents wearing double briefs. She said she normally observes her residents very close. She said she knows they wear briefs but do not know if they are care planned to wear briefs. She said wearing briefs increase the chance of residents having skin issues and urinary tract infections. During an interview on 3/25/2025 at 2:20pm with the RN G, she said she's aware of aides double briefing some residents. She said she never reported the inappropriate practice due to it becoming a normal thing in the facility. She said she's aware that she should have reported the neglectful practice. She said double briefing the residents and leaving them up in one position too long may increase the chance of skin break downs and urinary tract infections. During an interview on 3/25/2025 at 3:00pm with the DON she said she was not aware of staff double briefing residents. She said double briefing residents was a big no, no. She said a brief can increase chances of urinary tract infections and ulcers/sores. Double briefing will hold the moister, warmth and bacteria more and cause a greater chance for the resident to have negative effects from using briefs. During an interview on 3/25/2025 at 3:20pm with the administrator he said he did not know the staff were double briefing residents. He said double briefing is not proper practice and could cause negative effects to the residents by irritating their skin and increase chances of infections. Record review on 3/25/2025 of a facility policy titled Abuse/Neglect revised on March 29, 2018, read . The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse to any resident in the facility. Record review on 3/25/2025 of a facility policy titled Residents Rights dated 2003 revised on November 28, 2016, read . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Planning and implementing care-The resident has the right to be informed of, and participate in, his or her treatment, including: 1. The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. 2. The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: 3.The right to be informed, in advance, by the physician or other practitioner or professional that will furnish care. 4. The right to be informed in advance, by the physician or other practitioner or professional, of the risk and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. 5.The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assures the accurate acquiring, receiving, dispensing, and administering of medications for 1 of 6 residents (Resident #3) and reviewed for pharmacy services. The facility failed to ensure Resident #3 ingested all medications as prescribed and was not able to stash medications in room. On 10/31/2024 Resident #3 had a psychotic episode, and 40 to 50 pills were found on the floor in Resident #3's room. On 1/29/2024 Resident #3 had a psychotic episode, and 10 to 15 pills were found in Resident #3's room. These failures could place residents at risk for the unsafe administration of medications, not receiving prescribed doses of ordered medications and not receiving the intended therapeutic benefit of the medications. Findings included: Record review of facility electronic face sheet indicated Resident #3 was a [AGE] year-old female admitted to facility on 5/01/2024 with the most recent admission on 11/05/2024. Resident #3's diagnosis included: dementia (decline in mental ability), anxiety (excessive worry, fear, and nervousness), and bipolar disorder (extreme shifts in mood, energy, and behavior). Record Review of Resident #3's comprehensive care plan dated 1/08/2025 indicated Resident # 3 refused medications at times with intervention of a negotiated risk assessment signed. Resident #3 had impaired cognitive function dementia or impaired thought processes with an intervention to administer medications as ordered. Resident #3 had verbal behaviors threatening to kill roommate and staff with an intervention of assist resident in avoiding resident that may incite outburst. Resident #3 required antipsychotic medications with an intervention to administer medications as ordered, monitor and document for side effects and effectiveness. Record review of Resident #3's Quarterly MDS dated [DATE] indicated Resident #3 had a BIMS of 15 indicating no cognitive impairment. Record review of physician orders dated as of 1/29/2025 indicated Resident #3 had an order for acetaminiophen-codeine 300-60mg 1 tablet every 6 hours as needed, alprazolam 0.25mg 1 tablet at bedtime, amantadine 100mg 1 tablet twice daily, baclofen 10mg 1 tablet three times daily, ciprofloxacin 500mg 1 tablet twice daily, dicyclomine 20mg 1 tablet every 8 hours as needed, linzess 72mcg 1 tablet once a day, esomeprazole 40mg 1 tablet once a day, omega-3 capsule 1000mg 1 tablet once a day, oxcarbazepine 300mg give 2 tablets twice daily, probiotic capsule 1 capsule daily, rosuvastatin 5mg 1 tablet once daily, Seroquel 300mg 1 tablet twice daily, Seroquel 25mg 1 tablet twice daily, trazodone 50mg 2 tablets at bedtime, and Wellbutrin xl 150mg 1 tablet once daily. Record review of Resident #3's medication administration record dated 10/01/24-10/31/2024 revealed Resident #3 refused to take omega-3 on 10/29/24 and 10/31/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455959	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westward Trails Nursing and Rehabilitation	3001 Westward Dr Nacogdoches, TX 75964

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's medication administration record dated 1/01/25-1/31/2025 revealed Resident #3 refused to take omega-3 on 1/1/24, 1/15/24, 1/16/24, 1/17/24, 1/21/24, and 1/23/24. She refused linzess 72mcg on 1/2/25, 1/10/25, 1/20/25, 1/21/25, 1/23/25, 1/27/25, and 1/28/25. She refused probiotic 1/3/25, 1/11/25, and 1/23/25. She refused Wellbutrin xl 150mg on 1/6/25, 1/9/25, and 1/29/25. She refused amantadine 100mg on 1/1/25, 1/6/25, and 1/7/25. She refused baclofen 10mg on 1/4/25, 1/6/25, 1/13/25, 1/14/25, 1/15/25, 1/17/25, 1/20/25, 1/22/25, 1/23/25, 1/24/25, and 1/26/25. Record review of nursing progress note dated 10/31/2024 at 4:15 AM written by RN D indicated: .I talked with [Resident #3] and convinced her to get into her own bed. She started to cry, got up and got into her bed and covered her head. I saw multiple pills on the floor. I picked them all up. I called [psych doctor] and spoke with NP. She gave orders to go 1 to 1 with [Resident #3] if it were possible. She also stated that resident needs to go to an inpatient psych facility as soon as possible. During an interview on 3/25/2025 at 1:05 PM LVN E said Resident #3 had a psychotic episode on 10/31/2025. She said RN D went to Resident #3's room and during the psychotic episode found approximately 50 pills scattered on the floor. She said RN D picked up the pills and put them in a cup for the DON. She said the next time Resident #3 had a psychotic episode was on 1/29/2025 and said Resident #3's room was searched after she transferred to the inpatient psych hospital and 10 to 15 more pills were found in different places in Resident #3's room. During an interview on 3/25/2025 at 3:00 PM the DON said she could not remember which psychotic episode it was but there were about 12 pills found in Resident #3's room. She said she used the computer pill identifier and said the pills mostly consisted of Resident #3's linzess, probiotic, and omega-3. She said Resident #3 had taken her antipsychotic medications and it was mostly her vitamins that were found not taken. She said she did 1 to 1 education with the weekend medication nurse LVN F that consisted of an in-service about not leaving medications at bedside. The DON said her expectation was for all medications to be administered per facility policy and physicians orders. Record review of in-service dated 11/1/2024 titled Leaving Medications at Bedside signed by LVN F. During an interview on 3/26/2025 at 8:29 AM ADON A said during Resident #3's psychotic episode on 10/31/2025 there were approximately 20 pills found in a basket on Resident #3's bedside table, in Resident #3's purse, and in Resident #3's dresser drawer. She said she recognized some of the pills as a multivitamin and said some of the pills she did not recognize that could have maybe been a stool softener, she said there were not any narcotics and none of the medications were psych medications. She said the episode that happened on 1/29/2025 approximately 5 or 6 pills more pills were found in the basket in Resident #3's beside table. During an interview on 3/26/2025 at 10:49 AM RN D said on 10/31/2025 at about 4:00 AM she entered Resident #3's room due to Resident #3 having a psychotic episode. She said she felt something crunching under her feet and there were pills all over the floor. She said there were approximately 50 pills on the floor. She said she picked up all the pills and gave them to the day shift nurse LVN C the next morning to give to the DON. (continued on next page)

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	455959	A. Building B. Wing	03/31/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 11:21 AM RN G said she was on call the night of 10/31/2024 and received a call from RN D regarding Resident #3 having a psychotic episode. She said RN D told her she had found a bunch of pills on the floor in Resident #3's room. She said she did not give RN D any instruction on what to do with the pills. She said on 1/29/2025 Resident #3 had a similar psychotic episode and thought there were pills found in Resident #3's room again. During an interview on 3/26/2025 at 1:19 PM CNA H said on the night of 10/31/2025 she remembered Resident #3 having a psychotic episode and remembered seeing approximately 30-50 pills scattered all over the floor and behind her bed. She said RN D picked up all the pills and put them in a cup. She said it looked like Resident #3 had been stashing the pills and had knocked them over scattering them all over the floor. During an interview on 3/26/2025 at 2:55 PM the Administrator said it was his expectation for all medications to be administered per the physicians' orders and facility policy. He said no medications should be left at bedside. During an interview on 3/31/2025 at 11:37 AM LVN F said there was an incident that she did leave medications at bedside for Resident #3. She said Resident #3 requested her to leave her medications on her bedside table. She said one day she forgot to go back and check to make sure Resident #3 took the medications. She said when she left the medications at bedside, she means she went back to computer right outside the door not that she left the hall. She said Resident #3 was never out of her line of vision when taking her medications. She said she did not know where Resident #3 could have gotten the pills that were found. She said Resident #3 never refused medication and always took all her medications after it was explained to her what they were. She said Resident #3 was the only resident she left pills at bedside for. She said she was not aware of the pills that were found after the psychotic incident on 10/31/2024 or 1/29/2025. She said she had been in serviced upon hire regarding medication administration. She said she was aware she was not supposed leave medications at bedside. She said she had been in-serviced 1 on 1 regarding leaving medications at bedside. Record review of facility policy titled Medication Administration Procedures dated 10/25/17 indicated: 5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record. It is recommended that medication be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration. Initials are to be used. Check marks are not acceptable. During the medication administration process, the unlocked side of the cart must always be in full view of the nurse . 6. If a dose of regularly scheduled medication is withheld or refused, the nurse is to initial and circle the front of the medication administration record in the space provided for that dosage administration and an explanatory note is to be entered in the nursing notes or in the PRN nurses notes section of the medication administration record. In the presence of individual facility policies concerning refused and held documentation, the facility policy supersedes this policy .