STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675018	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Health and Rehabilitation Center	2416 NW 18th St Fort Worth, TX 76106

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observation, interview, and record review the facility failed to ensure the resident had the right to a safe, clean, comfortable, and homelike environment, which included but not limited to receiving treatment and supports for daily living safely for one of six residents (Resident#1) reviewed for environment. 1. The facility failed to properly clean and maintain a sanitary and comfortable environment free of foul odors for Resident#1 room. 2. The facility failed to maintain a safe environment for Resident#1 room. These failures could place residents at risk for a diminished quality of life due to the lack of a well-kept, home-like environment. Findings include: Record review of Resident#1's face sheet dated 12/20/24, reflected; Resident#1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident#1 was diagnosed with paranoid schizophrenia (a type of psychosis, which means your mind doesn't agree with reality), bipolar disorder (A serious mental illness characterized by extreme mood swings) They can include extreme excitement episodes or extreme depressive feelings)., other symptoms and signs involving appearance and behavior, unspecified Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, cognitive communication deficit(Impaired functioning of one or more cognitive process such as: attention, memory, organization, problem solving/reasoning and executive functions) unsteadiness on feet, muscle wasting and atrophy(thinning of muscle mass), not elsewhere classified, multiple sites. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident#1's quarterly MDS, dated [DATE] reflected; Resident#1 had a BIMS score of 15, which indicated cognition intact. Section C-Cognitive patterns reflected, Resident#1 was coded at a 2 for behavior present, fluctuate (comes and goes) for disorganized thinking (rambling, irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) and inattention- resident had difficult focusing attention for example, easily distracted. Section E- behavior reflected, Resident#1 had Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Section Functional abilities reflected, Resident#1 was coded refused for bath and showers. Resident#1 was coded independent for other functional activities. Section N-Medications coded 1 for yes : Antipsychotics were received on s routine basis only Record review of Resident#1's care plan dated,10/10/24 reflected focus . hoarding r/t Paranoid Schizophrenia, Bipolar, Non-Compliant with behavior w/cognitive impairment. Goal: fewer episodes of writing on walls/furniture. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Focus at risk for falls r/t Gait/balance problems, cognitive impairment, psychoactive medication drug usage. Goal: falls and/or injuries minimized thru management of risk factors while maintaining maximum independence and quality of life. Interventions: Anticipate and meet the resident's needs . Follow facility fall protocol. Record review of Resident#1's progress notes dated 07/01/24 to 12/23/24, reflected Progress note dated 11/07/24 by SS reflected Resident#1 allowed a staff to sweep a small part of the entry way to her room, but is still refusing staff to change her bedding and perform housekeeping inside her room. Progress note dated 11/14/24 b y SS reflected resident#1 is still resistive to housekeeping in her room and to proper hygiene. Progress note dated 11/27/24 by SS reflected, Resident#1 IDT team met to discuss the ongoing concerns regarding this resident. She continues to deny access to housekeeping staff to clean her room. The nursing staff is unable to complete the skin assessments and the resident continues to be non-compliant for hygiene. Attempts to care for this resident completed in-house by the facility have failed. Psych services advised that the state hospital may better fitthis resident's needs. Progress note dated 12/03/24 by SS reflected Housekeeping reported that this resident is defecating behind her bedroom door after noticing poop on the floor. While they were cleaning her room, they also noticed that this resident is also urinating in the trash can in her room. This resident is not allowing maintenance in her room to check if the restroom is working. Observation on 12/20/24 at 5:35 AM revealed a strong smell of urine that permeated the South 3 hallway . Observed HK C open Resident#1 door. The smell of urine and feces that came from the room was overwhelming. Observed urine in cups, clothes, pizza boxes personal items thrown around the room and no free space to walk from one end of the room to the next. Observed writing on the wall inside and outside the resident room. Interview on 12/20/24 at 5:41 AM, the HK C stated Resident#1 had gone to the hospital yesterday. The HK stated Resident#1 would not allow staff in her room to clean it for a long time. The HK C stated Resident#1 would cuss and get aggressive with staff. The Housekeeper stated Resident#1 allowed her to swap up feces one time behind the door and told her to get out. The Housekeeper stated she removed a bucket of dirty linen from Resident#1's room that resident took from the hallway and put in her room. The Housekeeper stated Resident#1 had refused services since she been here.HK C stated they let the nurse staff and Admin A know that resident was refusing care. HK C would come back to the resident room later and see if you would allow HK C not clean room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/20/24 at 6:20 AM the HKSP D stated Resident#1 did not allow staff in her room to assist her with anything. The HKSP D stated Resident#1 took BM'S in plastic bags and would urine in cups. The HKSP D stated she was going to try and clean Resident#1 room today. HKSP D stated when Resident#1 refused services we let the DON B and Admin A know and try again later to provide housekeeping services. Attempted to interview Resident#1 on 12/23/24 at 8:30 AM at the hospital. Resident#1 was not able to answer questions about the facility. Observation on 12/20/24 at 11:15 AM the HKSP D bagged up Resident#1's personal items and removed items Resident#1 had took from the facility that was left in the highway for example: pillowcases, sheets, wipes and trash bags. Interview on 12/20/24 at 11:20 AM, the Admin A and DON B stated Resident#1 had been in the facility since 2015. Since she has been there, she would hoard, constantly refuse showers, nail care, dental care, vision care, and refuse housekeeping, maintence and nursing staff access to her room. The DON B stated Resident#1 would creep out of her room [ROOM NUMBER] pm to 6am and grab linen, wipes, any staff or residents' personal items that were left out. The DON B stated she had taken a resident's radio that was found in her room. The Admin A and DON B both stated that since August they had noticed a big change of condition and her behaviors had gotten worst like voiding in plastic bags - BM and Urine, odor progressively worst since July. Resident#1 would not let staff in the room. The DON B stated the smell of Resident#1 room overwhelmed her and she had no idea she had all that stuff in there. The DON B stated several residents did complain about Resident#1's odor (Residents with the complaints were not confirmed). Admin A and DON B stated they held meetings with the IDT, guardian, Psy MD, NP, PCP about Resident#1 behavior and it was determined the facility can not met Resident#1 needs, The Admin A and DON B stated the room was not sanitary. Interview on 12/23/24 at 1:00 PM, the SS stated she started to work for the facility at the beginning of October and was told about Resident#1 behaviors. The SS had contacted Guardian to speak with Resident#1 and she never did. Attempted to call Resident#1 guardian at 11:43 AM on 12/23/24 and not able to leave voicemail. Attempted to call Psy MD on 12/23/24 at 11:44 AM and received no return call. Attempted to call PCP on 12/23/24 at 11:47 AM and received no return call. Attempted to call NP on 12/23/24 at 12:13 PM and received no return call. Record review of facility's admission packet Nursing Facility Residents; Rights, dated 11/2021, reflected .you have the right to: live in safe, decent and clean conditions

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable for 1 of 4 resident (Resident # 1) reviewed for activities of daily living. The facility failed to ensure Resident #1 was provided care and services for hygiene. This failure could place residents at risk for poor self-esteem, infections, socialization, ADL decline and diminished quality of life. Findings included: Record review of Resident#1's face sheet dated 12/20/24, reflected; Resident#1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident#1 was diagnosed with paranoid schizophrenia (a type of psychosis, which means your mind doesn't agree with reality), bipolar disorder (A serious mental illness characterized by extreme mood swings) They can include extreme excitement episodes or extreme depressive feelings)., other symptoms and signs involving appearance and behavior, unspecified Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, cognitive communication deficit(Impaired functioning of one or more cognitive process such as: attention, memory, organization, problem solving/reasoning and executive functions) unsteadiness on feet, muscle wasting and atrophy(thinning of muscle mass), not elsewhere classified, multiple sites. Record review of Resident#1's quarterly MDS, dated [DATE] reflected; Resident#1 had a BIMS score of 15, which indicated cognition intact. Section C-Cognitive patterns reflected, Resident#1 was coded at a 2 for behavior present, fluctuate (comes and goes) for disorganized thinking (rambling, irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) and inattention- resident had difficult focusing attention for example, easily distracted. Section E- behavior reflected, Resident#1 had Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Section Functional abilities reflected, Resident#1 was coded refused for bath and showers. Resident#1 was coded independent for other functional activities. Section N-Medications coded 1 for yes : Antipsychotics were received on s routine basis only Record review of Resident#1's care plan dated 10/10/24, reflected focus Resident #1 has an ADL self-care deficit r/t bipolar with agitative behavior. Goal: Resident :will maintain current level of function .:Intervention: Bathing: the resident is is independent with showering in the evenings, but requires supervision. Record review of Resident#1's progress note s dated 07/01/24 to 12/23/24 , reflected: 07/02/24: Patient refused shower. Patient stated, I don't need one. by LVN E (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/02/24: Resident refused shower by by LVN E 07/04/24: Patient refused shower by LVN E 07/09/24: Patient refused shower. Patient stated, I don't need one. by LVN E 07/11/24: Patient refused shower. Patient stated, I don't need one by LVN E 07/16/24: Refused shower. Patient stated, [NAME], I don't need one. By LVN E 07/18/24: Patient refused shower. Patient stated, I'm not dirty. I'm not going to take a shower here. by LVN E 07/23/24: Resident refused shower. by LVN E 07/25/24: patient refused shower. Patient stated, I don't stink. by LVN E 07/30/24: Patient refused shower. Patient stated, I don't smell. You smell. Why don't you go take one. By LVN F 08/01/24: patient refused shower. Patient stated, I don't need one. by LVN E 08/06/24: Refused shower. by LVN E 08/08/24: Patient refused shower. Patient stated, I don't smell. by LVN E 08/20/24 : Patient refused shower. Patient stated, No! by LVN E 08/31/24: Patient refused shower. Patient stated, I don't need one. by LVN E 09/03/24: Patient refused shower. I do not stink! by LVN E 09/05/24: Patient refused shower. Patient stated, [NAME], I don't think so. by LVN E 09/10/24: Patient refused shower. I don't need one. by LVN E 09/17/24: Patient refused shower. Patient stated, No! by LVN E 10/01/24: Patient refused shower. Patient stated, I don't stink! by LVN E 10/17/24: patient refused shower. Patient stated, I don't stink! by LVN E 10/24/24: Patient refused shower. Patient stated, I don't smell! by LVN E 10/27/24: Observed resident standing in doorway requesting trash receptacle to be placed near her door because she had items to place in trash. When barrel was brought to door resident placed a plastic bag of urine with a knot tying the bag closed. When asked why she was putting urine into a bag stated My bathroom works but I don't used the public system. By RN G (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/29/24: Patient refused shower. Patient stated, I'm clean! I don't need to take a shower! LVN E 11/05/24: Patient refused shower. Patient stated, I am clean. LVN E 11/13/24: Resident refused to take shower. LVN E 11/14/24: Patient refused shower. Patient stated, I don't need one. LVN E 11/21/24: Patient refused shower x 3. Patient stated, I told you. I don't stink. LVN E 11/26/24: Patient refused shower x 3. Patient stated, Do you think I stink? Why don't you take a shower! LVN E 12/03/24: Patient refused shower x 3. Patient stated, I'm not taking a shower. LVN E 12/10/24 : Patient refused shower x 3. Patient stated, I don't need a shower. You need a shower. LVN E 12/19/24: DON, administrator, Guardian and PCP met and discussed behaviors and how [Psych MD.] and NP had expressed their concerns about the resident's safety.Dr. is in agreement with psych recommendations. [PCP] also feel that resident is a threat to self and others. Concerns reagrding her environment were also discussed. The Guardian is in agreement that the resident needs to be evaluated at a hihger of level of care. After the discussion, we called for ambulance per [PCP]order and [NP] recommendation. arrived on scene, the Guardian presented them with a copy of her court documentation noting guardianship. They assessed the resident, called their physician and he agreed with transfer. Resident was verbally aggressive toward paramedic. She actually voided in a water pitcher while they were in attendance. When asked why she was doing that (she has a bathroom in her room) she replied that she was measuring her urine output. When offered to have the pitcher of urine emptied, she refused to allow it stating that she needed ice cubes to preserve it. At this point Paramedic called for PD back up. Resident was verbally aggressive and resistant even with the police in sight. Administrator was able to calm her down. Record review of the Hospital record dated, 12/23/24 reflected: Resident #1 was awake and alert and refused vital signs, to change clothes and bathe on 12/20/24, 12/21/24,12/22/24 and 12/23/24. 6 facilities have been sent Resident#1 paperwork and 2 have so far declined for behaviors . Record review of Letter from Director of clinical care of psychiatric services, dated 12/19/24 reflected: Resident#1 has been under psychiatric care services since November 25,2019 .Over the course of the last few months, she has been refusing to take her antipsychotic medication. Her behaviors have increased including delusions, defecting, and urinating in plastic bags and placing them in dresser drawers in her room. Patient refuses showers and exhibit a strong odor, staff are not sure of the condition of her skin or hair. She refuses to allow staff into her room and the facility had to have police intervention to remove prescription medication from the patient room. The patients behaviors including aggression, threats to staff, paranoia, and delusions have increased with refusals. Her current setting is unable to effectively address psychiatric needs. I recommend transferring the patient to a higher level of care for psychiatric care and mental health management. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/19/24 at 6:30 PM RN I, stated Resident#1 refused all care from staff. Resident#1 would not take showers or allow staff to clean resident room. RN I, stated Resident#1 refused all care. RN I, stated staff would try to educate resident on the importance of bathing and resident would cuss staff out. Interview on 12/20/24 at 5:33 AM LVN J stated Resident#1 refused care from staff and was aggressive. LVN J stated staff would make three attempts to provide Resident#1 care. Interview on 12/20/24 at 11:30 AM with the Administrator and DON, both stated they cannot meet the resident's needs. The Administrator stated they did not know what they were going to do about the resident and they were waiting on Corporate. The Administrator stated she has been here since July 2024 and the resident has refused care, aggressive towards staff and would not let staff in her room. The Administrator stated the last couple of months of gotten worse. Attempted to interview and observation on 12/23/24 at 8:30 AM reflected Resident#1 at the hospital. Resident#1 was not able to answer questions about the facility. Resident#1 had a odor of urine that could be smelled from the doorway. Resident#1 hair was oily, greasy and her legs and feet appeared to be dry and ashy. Interview on 12/23/24 at 9:30 AM hospital social worker stated she was told that the facility was not taking the resident back . The Hospital social worker stated the guardian stated she did not receive discharge information. Interview on 12/23/24 at 11:30 AM the Director of guardianship stated they did receive immediate discharge information on 12/20/24 around 4pm and they will appeal the decision. The Director of guardianship stated the facility needed a warrant and needed the guardian approval. The Director of guardianship stated they granted it because the facility said they would take the resident back and now it will be hard to place her because of her behaviors, she has been at the facility for 9 years. Attempted to call Resident#1 guardian at 11:43 AM on 12/23/24 and not able to leave voicemail. Attempted to call Psy MD on 12/23/24 at 11:44 AM and received no return call. Attempted to call PCP on 12/23/24 at 11:47 AM and received no return call. Attempted to call NP on 12/23/24 at 12:13 PM and received no return call. Interview on 12/23/24 at 12:25 PM with on-call ombudsman stated the facility had contacted the ombudsman office and needed to do an emergency discharge for Resident#1. Ombudsman stated the facility stated they could not meet Resident#1 needs. Interview on 12/23/24 at 1:00 PM, the SS stated she started to work for the facility at the beginning of October and was told about Resident#1 behaviors. The SS had contacted Guardian to speak with Resident#1 and she never did. Interview on 12/23/24 at 1:30 PM LVNE stated Resident#1 refused all care from staff. LVN E stated three attempts would be made throughout the day to provide care to Resident#1. LVN E stated when Resident#1 refused care it was documented in the progress notes. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/23/24 at 2:00 PM the Admin A stated that Resident#1 cannot come back unless she was stable and the hospital records showed adjustments on medications. The Admin A stated the Psy MD stated it would be easier for Resident#1 to transfer to a state hospital from the hospital. The Administrator stated they cannot meet her social, mental and psychology needs there.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46403 Based on 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 4 residents (Residents #1), reviewed for pharmaceutical services, in that: The facility failed to ensure Resident #1 took olanzapine 10 mg tablet that was ordered to be taken: 1 tablet by mouth twice a day. DON B found 28 of what appeared to be Olanzapine tablets in 3 drawers of Resident#1 bedside nightstand. This failure could place residents at risk for not receiving medication as ordered. The findings included: Record review of Resident#1's face sheet dated 12/20/24, reflected; Resident#1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident#1 was diagnosed with paranoid schizophrenia (a type of psychosis, which means your mind doesn't agree with reality), bipolar disorder (A serious mental illness characterized by extreme mood swings) They can include extreme excitement episodes or extreme depressive feelings)., other symptoms and signs involving appearance and behavior, unspecified Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, cognitive communication deficit(Impaired functioning of one or more cognitive process such as: attention, memory, organization, problem solving/reasoning and executive functions) unsteadiness on feet, muscle wasting and atrophy(thinning of muscle mass), not elsewhere classified, multiple sites. Record review of Resident#1's quarterly MDS, dated [DATE] reflected; Resident#1 had a BIMS score of 15, which indicated cognition intact. Section C-Cognitive patterns reflected, Resident#1 was coded at a 2 for behavior present, fluctuate (comes and goes) for disorganized thinking (rambling, irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) and inattention- resident had difficult focusing attention for example, easily distracted. Section E- behavior reflected, Resident#1 had Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Section Functional abilities reflected, Resident#1 was coded refused for bath and showers. Resident#1 was coded independent for other functional activities. Section N-Medications coded 1 for yes : Antipsychotics were received on s routine basis only Record review of Resident#1's care plan dated, 10/10/24, reflected focus . hoarding r/t Paranoid Schizophrenia, Bipolar, Non-Compliant with behavior w/cognitive impairment. Goal: fewer episodes of writing on walls/furniture. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness . (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus Resident requires psychotropic medications Olanzapine, Risperdal for diagnosis of Schizophrenia, Bipolar. Goal: Resident will remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment. Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness . Focus: Resident#1 non-compliant with receiving psychoactive medication injection Goal: Resident needs will be met during the next 90 days . Intervention: Notify family and physician of behavior/refusal of care . Record review of December 2024 progress notes reflected: 12/18/24: CMA reported that resident accepted cup with medicine and put it to mouth as though she was taking medication. Resident returned medicine cup to CMA then turned her back to CMA and reached in to drawer, CMA observed several pills in drawer before resident closed drawer. CMA asked if he could look in drawer, resident stated No. and walked back to bed. CMA exited room and reported to charge nurse. DON, administrator notified. By LVN J 12/18/24: DON and Administrator went to resident room to discuss what was reported CMA. Resident denied having any medication in her room or drawer. By RN I 12/18/24: PD Assisted with search of drawers for medication. DON found 28 of what appeared to be Olanzapine tablets in 3 drawers of bedside nightstand. Markings on the pills were difficult to read or were absent. The pills are similar in shape, size and color to the pills in the medication card. The pills appeared to have been in some kind of liquid and were sticking together. Resident was angry yelling for DON to get out of my stuff and out of my room. You are stealing my stuff The police told me that I could keep my samples and do not give them to you as you are a junkie and will take them or sell them. Psych services notified and PCP notified by DON B Interview on 12/19/24 at 6:30 PM RN I, stated Resident#1 refused all care from staff. Resident#1 would not take showers or allow staff to clean resident room. RN I, stated Resident#1 refused to take her Risperdal injections and Olanzapine pills were found in the resident drawers. Resident would take the medications from her room door and would cuss at the staff and close the door. Interview on 12/20/24 at 5:33 AM LVN J stated Resident#1 refused care from staff and was aggressive. LVN J stated police were called to help DON retrieve medication from the resident drawers on 12/18/24. Interview on 12/20/24 at 11:30 AM with the Admin A and DON B stated they were informed by nursing staff that Resident#1 had a drawer of medications. DON B stated Resident#1 had between 25 to 28 pills that looked like Olanzapine tablets. DON B stated Olanzapine tablets were in a wad and looked like that had been spit out. Record review of facility's policy Medication Administration, Refusal of Medication(s), undated, reflected The resident will not experience adverse effects from noncompliance with refusal of prescribed medications.