STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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	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** 47358 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to include procedures that assured the accurate administration of all drugs to meet the needs of each resident for 15 of 44 residents (CR # 1, CR # 2, Resident # 3, Resident # 4, Resident # 5, Resident # 6, Resident # 7, Resident# 8, Resident # 9, Resident # 10, Resident # 11, Resident # 12, Resident # 13, Resident # 14, and Resident # 15) reviewed for pharmacy services. The facility failed to ensure medications that were scheduled three and four times daily were administered at their scheduled times, resulting in medications being administered with only 2-4 hours between doses for Residents (CR # 1, CR# 2, Resident # 3, Resident # 4, Resident #5, Resident # 6, Resident # 7, Resident #8, Resident # 9, Resident # 10, Resident # 11, Resident # 12, Resident # 13, Resident # 14, and Resident # 15). The facility failed to ensure medications were administered timely between 7/22/2024 and 7/31/2024 which resulted in extremely late administration, up to 8 hours, of medications, such as insulin, diuretic, anticonvulsant, anticoagulant, anti-hypertensive, anti-depressive, and hypoglycemia. These failures placed residents at risk of experiencing exacerbation of pain and other health and psychiatric diagnoses, harmful drug to drug interactions, and other serious health related complications from taking prescribed medication after the scheduled times. Findings include: (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview during medication pass with LVN A on 7/31/2024 at 1:00 pm, LVN A stated she passed morning and afternoon medications to 100 hall and 200 hall (approximately 40 residents). Other than the memory care unit. She said that on 7/31/2024 (approximately 6:00 am) she stated that the DON called her and informed her that she would pass medication on 7/31/2024 as MA A would not report to work. She said her shift was from 8:00 am-8:00 pm. She said she does not pass medication. She said she began passing medication on 100 hall at 8:15 am. She said being that she had not passed medication at this facility she was a little slow. She stated that she had given medication to residents on hallway one and she was giving medication to resident on hallway two. LVN A said she still had to pass medications to the residents on 200 hall (ten residents) and all the resident's medication were red on the EMAR at 1:15 pm, indicating they were all late at that time. Observation of the computer screen at that time revealed the medication on each resident's EMAR were highlighted red. LVN A said she was doing her best to administer medication to the residents. She stated that a contractor arrived at 11:00 am to assist with passing medication. CR # 1 Record review of CR # 1's face sheet, undated, revealed a [AGE] year-old male admitted to the facility on [DATE]. CR # 1 was discharged to the community on 7/31/2024 at 9:06 am. CR # 1's diagnoses included: Alcoholic cirrhosis of liver with ascites (a complication of alcoholic liver disease that occurs when fluid builds up in the peritoneal cavity), Other seizures (uncontrolled jerking, loss of unconsciousness), Hypokalemia (blood level low in potassium, anemia (lack of blood),Hypothyroidism, unspecified (a condition in which the thyroid gland doesn't produce enough thyroid hormone),hypotension (low blood pressure), Chronic kidney disease, stage 3 (when kidneys are moderately damaged and have difficulty filtering waste and fluid from the blood), Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria, abnormalities of gait and mobility, Cognitive communication deficit, Weakness, Muscle wasting and atrophy, not elsewhere classified, right lower leg, Muscle wasting and atrophy, not elsewhere classified, left lower leg, Dysphagia(difficulty swallowing), oropharyngeal phase, Gastro-esophageal reflux disease without esophagitis, Other recurrent depressive disorders. Record review of CR # 1's MDS, dated [DATE] revealed he rarely/never made himself understood and rarely/never understood others; he had a BIMS score of 13 (cognition is intact) he exhibited behaviors related to rejection of care within 4 to 6 days; he required extensive physical assistance from at least 2 staff for bed mobility and transfers; he required extensive physical assistance from at least one staff for eating and toilet use. Record review of CR #1's Care plan, last revised date 7/1/2024, revealed the following care areas: * CR # 1 was taking antibiotic therapy r/t Encephalopathy (medication Neomycin). Goal included he will receive therapeutic treatment from medication with no complications. Intervention included: a Licensed nurse would monitor for side effects including nausea, dizziness, muscle pain, respiratory distress, digestive upset, decreased cognition and report abnormal findings to physician. *CR # 1 had a diagnosis of GERD. Goal included CR # 1 would be free of gastric pain. Interventions included: medication administered as order, Monitor for side effects. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*CR # 1 required the use of diuretic medication r/ t chronic kidney disease. Goal included CR # 1 would not exhibit signs of side effects of complications secondary to diuretic use. Interventions included: Administer medication as ordered by doctor. Monitor for side effects. *CR # 1 had diagnosis of Hypothyroidism. Goal included: CR # 1 will be free of edema, weight gain, and electrolyte imbalance. Interventions included: Administer medication as ordered by doctor. Monitor for side effects. Assess for fluid excess (weight gain, increased P; full/bounding pulse, jugular vein distention, OB, moist cough, rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output, nausea/vomiting; liquid stools, confusion, seizures. *CR # 1 had a diagnosis of Alcoholic cirrhosis of the liver with ascites. Goal included: CR # 1 would not exhibit signs of fluid volume excess. Interventions included: Administer medication as ordered by doctor. Monitor for side effects. Assess for fluid excess (weight gain, increased P; full/bounding pulse, jugular vein distention, OB, moist cough, rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output, nausea/vomiting; liquid stools, confusion, seizures. *CR # 1 had a diagnosis of seizures. Goal included: CR # 1 will not injure self-secondary to seizure disorder. Interventions included: Administer medication as ordered by doctor. If seizure occurs, remove all restrictive clothing and objects of potential harm. Turn head to side to maintain patent airway. *CR # 1 had a diagnosis of chronic kidney disease stage 3. Goal included: CR # 1 will maintain or improve current kidney function. Interventions included: Administer medications and obtain labs per provider order. Notify provider of any change in condition. *CR # 1 had a diagnosis of Hypotension. Goal included: Promote vascular perfusion as evidenced by: no development of blood clot, Blood Pressure is within resident's normal range, and, no occurrence of chest pain. Interventions included: Administer medication as ordered by doctors. Monitor medication/s' effectiveness and watch for severe adverse reaction as needed. Record review of CR # 1's physician's order for July 2024 revealed the following active orders: *Keppra tablet; 500 mg; Give 1 tablet by mouth twice a day (10:00 am and 7:00 pm) for seizures, *Lasix (furosemide) tablet; 40 mg give 1 tablet by mouth twice a day (10:00 am and 7:00 pm) for chronic kidney disease stage 3, Levothyroxine tablet; 125 mcg; Give 1 tablet by mouth once a day (6:00 am) for hypothyroidism, *Midrone tablet; 5 mg give 1 tablet by mouth three times a day (10:00 am, 4:00 pm and 10:00 pm) for hypotenson, *Potassium Chloride tablet; ER particles/crystals' 20 mEq; Give 1 tablet by mouth once a day (9:00 am) for hypokalemia, *Neonmycin tablet; 500 mg Give 1 tablet by mouth once a day (9:00 am) for alcoholic cirrhosis of liver with ascites (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Spironolactone tablet; 1 tablet by mouth once a day (10:00 am) for alcoholic cirrhosis of liver with ascites. Record review of CR # 1's physician's order for July 31, 2024 at 1;50 pm he was not administered the following medication as scheduled due to POA refused. *Keppra tablet, *Lasix (furosemide), *Levothyroxine, *Midrone, *Potassium Chloride, *Neonmycin, and *Spironolactone. Observation and interview of LVN A on 7/31/2024 at 1:00 p.m., administering Lactulose solution to CR # 1. LVN A said CR #1's POA requested that she give the Lactulose and the remaining medication to include: Keppra, Lasix (furosemide),Levothyroxine, Midrone, Potassium Chloride, Neomycin, and Spironolactone. Observation and Interview with CR# 1 on 7/31/2024 at 1:00 pm revealed the discharge date on the face sheet was inaccurate. CR# 2 Record review of CR # 2's face sheet, undated, revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. CR # 2 was discharged to the community on 7/31/2024 at 3:53 am. CR #2's diagnoses included: Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (partial paralysis on one side of the body) Weakness, , edema(fluid retention), Familial hypercholesterolemia(high cholesterol level), Human immunodeficiency virus [HIV] disease(a virus that attack cells),Type 2 diabetes mellitus without complications (high blood sugar) Hyperlipidemia(high level of fat in the blood), Hypokalemia (low potassium)Major depressive disorder(mental disorder that involves low mood), Guillain-Barre syndrome(immune system attacks the nerves), hypertension (high blood pressure). Record review of CR # 2's discharged MDS dated [DATE] revealed he was discharged to home/community; he made decisions regarding task for daily life; he did not have altered level of consciousness; he did not have any indicators of psychosis; he did not exhibit rejection of care; supervision or touching assistance needed for eating; partial or moderate assistance needed for oral and personal hygiene; substantial/maximum assistance needed for toileting hygiene, showering, bathing, lower body dressing, and putting on and taking off footwear. Substantial/maximal assistance for chair/to bed chair transfer, toilet transfer, tub/shower transfer; frequent urine and bowel incontinent. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CR #2's MAR dated 7/28/2024-7/31/2024 reflected the following: 7/28/2024 CR # 2's pulse rate was 73 and blood pressure 129/93 7/29/2024 CR #2's pulse rate was 72 and blood pressure 122/84 7/30/2024 CR # 2's pulse rate was 86 and blood pressure 125/92 Record review of CR # 2's care plan, revised 7/12/2024 revealed the following care areas: *CR # 2 is currently taking Eliquis for history of DVT. Goal included: CR # 2 will have no active bleeding. Intervention included: Administer anticoagulants as ordered; observe for signs of active bleeding (nosebleed, bleeding gums, petechiae, pain in joint and abnormal pain) *CR # 2 receives antidepressant medication R/T history of Depression. Goals included: CR # 2 will be prescribed the lowest effect dose. Interventions included: Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Monitor mood and response to medication. Monitor for effectiveness of medication. Provide medication as ordered. Record review of CR #2's physician's orders for July 2024 revealed the following active orders: *Amlodipine tablet; 10 mg; Give 1 tablet by mouth once a day (10:00 am) for hypertensive heart disease without heart failure *Biktarvy {bictegrav-emtricit-tenofov ala) tablet; 50-200-25 mg; Give 1 tablet by mouth once a day (10:00 am) for immunodefiency virus, *Eliqius tablet; 2.5 mg. Give 1 table twice a day (10:00 am and 5:00 pm) for hemiplegia and hemiparesis * Hydrochlorothiazide tablet; 25 mg, Give 1 tablet once a day (10:00 am) for hyperaldosteronism *Metoprolol tartrate tablet; 50 mg; Give 1 tablet by mouth once a day (10:00 am) for hypertensive heart disease without heart failure. *Pantoprazole tablet; 40 mg; Give 1 tablet by mouth once a day (10:00 am) for hyperaldosteronism *Potassium chloride capsule, extended release; 10 mEq; amt: Give 1 packet by mouth once a day (10:00 am) for hypertensive heart disease without heart failure. Record review of the facility's Medication Administration Compliance Report for 7/31/2024-8/2/2024 revealed the following for CR # 2: *Amlodipine tablet- scheduled daily for 10:00 am was administered at 2:15 pm on 7/31/2024 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Biktarvy tablet- scheduled daily for 10:00 am was administered at 2:16 p m on 7/31/2024 *Eliquis tablet- scheduled daily for 10:00 am was administered at 2:15 pm on 7/31/2024 *Hydrochlorothiazide tablet-scheduled daily for 10:00 am was administered on 2:15 pm on 7/31/2024 *Pantoprazole tablet- scheduled daily for 10:00 am was administered on 2:15 pm on 7/31/2024 *Potassium Chloride capsule-scheduled daily for 10:00 am was administered on 2:15 pm on 7/31/2024 Observation and interview with CR # 2 on 7/31/2024 at 1:20 pm reveals the discharge date on the face sheet was inaccurate. Resident # 3 Record review of Resident # 3's face sheet, undated, revealed a 68year-old male who was admitted to the facility on [DATE]. Resident # 3's diagnoses included: Cerebral palsy (a congenital disorder of movement, muscle, tone or posture), muscle weakness, muscle atrophy (a gradual process that involves loss of muscle tissue), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), schizoaffective disorder (a combination of two mental illnesses schizophrenia and mood disorder). Psychotic disorder (mental disorder characterized by a disconnection from reality), hypertension (high blood pressure) dementia (a group of thinking and social symptoms that interferes with daily functioning) and seizures (uncontrolled jerking and loss of consciousness). Review of Resident # 3's MDS dated [DATE] revealed he is usually understood; he had a BIMS score of 13 (cognition is intact); he did not exhibit behaviors related to rejection of care; he requires extensive assistance for bed mobility, transfer from at least two or more staff; supervision for eating help is required from staff; total dependence for toilet use from at least two or more staff. Review of Resident # 3's care plan, revised on 5/22/2024 revealed the following care area: *Resident # 3 receives antipsychotic medication R/T schizoaffective disorder, bipolar type. Goal included: Resident # 3 will not experience adverse side effects from medication thru the next review date. Interventions included: Administer medications as ordered per doctors and monitor side effects; Assess if the resident's behavioral symptoms present a danger to the resident and/or other, intervene as needed; Attempt gradual dose reductions as needed; monitor resident's behavior and response to medication *Resident # 3 has a diagnosis of Bipolar and Depression. Goals included Resident # 3 will have no unaddressed complication r/t Depression thru the next review date. Interventions included: Administer medication as ordered per doctor. Ensure that consent is obtained prior to administering medication. Monitor for side effects of Antidepressant. Monitor resident for side effects. *Resident # 3 is at risk for injury related to seizure disorder. Goals included Resident # 3 will not injure self-secondary to seizure disorder. Interventions included: Administer medications as ordered. Assess characteristics before, during and after seizure. Order labs as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Resident # 3 has a diagnosis of hypertension. Goals included: Resident# 3 blood pressure will stay within normal limits and will not have any signs and symptoms hyper/hypotension thru the next review dates. Interventions included: Administer all medications as ordered by doctor. Take and record blood pressure and heart rate before administering hypertensive medications. Record review of Resident # 3's physician's orders for July 2024 revealed the following active mediation orders: *Aricept (donepezil) tablet; 10 mg; Give 1 tablet by mouth at bedtime (8:00 pm) for Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety *Baclofen tablet; 10 mg; Give 1 tablet by mouth three times a day (8:30 am, 2:00 pm and 8:00 pm) for pain * Carbamazepine tablet; 200 mg; Give 1 tablet by mouth twice a day (8:30 am and 8:00 pm) for seizures *Depakote Sprinkles (divalproex capsule; 125 mg, Give 1 capsule by mouth three times a day (8:30 am, 2:00 pm and 8:00 pm) for major depressive disorder * Memantine tablet; 10 mg; Give 1 tablet twice a day (8:30 am and 8:00 pm) for unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety *Seroquel (quetiapine) tablet; 50 mg; Give 1 tablet twice daily (8:30 am and 8:00 pm) for schizoaffective disorder, bipolar. Record review of the facility's Medication Administration Compliance Report for 7/31/2024- 8/2/2024 revealed the following medications on 8/1/24 scheduled for 8:00 p.m., was administered at 10:17 p.m.: *Aricept (donepezil) tablet,- *Baclofen tablet,- * Carbamazepine tablet- *Depakote Sprinkles capsule * Memantine tablet- *Seroquel tablet- Resident # 4 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 4's face sheet, undated revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident # 5's diagnoses included: Acute respiratory failure with d (results from inadequate gas exchange by the respiratory system), nontraumatic intracerebral hemorrhage, (bleeding in the brain that is not caused by trauma), Unspecified dementia (a condition where a person has dementia but doesn't have a specific diagnosis), muscle wasting and atrophy (wasting or thinning of muscle mass), weakness, bacterial pneumonia (a type of pneumonia caused by bacterial infection), diabetes mellitus (too much sugar in the blood) and hypertension (high blood pressure). Record review of Resident # 4's care plan revised 7/15/2024 revealed the following care areas: *Resident # 4 has a potential for complications related to pneumonia. Goals include: Resident # 4 will not exhibit signs of pneumonia or complications from pneumonia. Interventions included: Administer Levofloxacin x 5 days. Evaluate/record/report effectiveness and any adverse side effects. Monitor and report emergence of complications. *Resident # 4 has behavior episode AEB. Goals included: Resident # 4 will have a reduction in unwanted mood or behaviors for an increased quality of life. Interventions included: Give medication as ordered monitor for side effects and effectiveness. Notify family of changes. Ensure physical needs are met, Licensed Nurse to assess and treat the resident's description of pain. *Resident # 4 has a history of respiratory failure with trach placement. Goals included: Resident # 4 will not exhibit or develop respiratory distress as evidenced by no shortness of breath, o2 sat at or above 95%. Interventions included: Administer breathing treatments as ordered. Administer medications as ordered. *Resident # 4 has diagnosis of hyperlipidemia and hypertension. Goal included: Promote vascular perfusion as evident by blood pressure is within normal range and no occurrence of chest pain. Intervention included: Administer medications as ordered. Monitor medication effectiveness. *Resident # 4 has a history of CVA intracerebral hemorrhage with left side paralysis. Goal included: Resident # 4 will not develop CVA over the next 90 days. Intervention included: Give medication as ordered by doctor. Monitor for acute changes. *Resident # 4 has a history of diabetes. Goal included: Reduce the risk of complications as evidenced by managing blood sugar level documented under the MAR. Interventions included: Administer medication as ordered. Monitor for signs and symptoms of adverse reactions. Report to doctor as indicated. Monitor blood sugar as ordered. Record review of Resident # 4's physician's orders for July 2024 revealed the following active medication orders: *Lantus U-100 Insulin (insulin glargine) 100 unit/mL solution 15 units Subcutaneous at bedtime (8:00 pm) for type 2 diabetes mellitus with unspecified complications *Acidophilus-Pectin (lactobacillus acdioph-pectin) 75 million cell-100 mg capsule; give 1 capsule gastric tube three times a day every 8 hours (8:00 am, 12:00 pm and 4:00 pm) for gastrostomy status. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Ipratropium Bromide spray non-aerosol; 21 mcg (0.03%) spray; administer 2 sprays; nasal: Give 2 nasal sprays three times a day 10:00 am, 1:00 pm and 6:00 pm) for pulmonary obstructive disorder Record review of Resident # 5's Medication Administration Compliance Report for 7/31/2024-8/2/2024 revealed the following for Resident # 5: *Ipratropium bromide spray-scheduled for 1:00 pm was administered 2:19 pm on 7/31/2024. Resident # 6 Record review of Resident # 6's face sheet, undated revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident # 6's diagnoses included: Alzheimer's disease (a progressive disease that destroys memory), dementia (a group of thinking and social symptoms that interferes with daily functioning) and localized swelling mass and lump lower limb bilateral. Record review of Resident # 6's MDS dated [DATE] revealed she sometimes made himself understood; he had a BIMS 02 (severe cognitive impairment); he does not exhibit behaviors related to rejection of care; he does not use any mobility devices; he needs supervision for eating; he needs partial/moderate assistance for oral and physical hygiene, toileting, showering, bathing, upper and lower body dressing. Supervision with toilet transfer, tub/shower transfer, frequent urine, and bowel incontinent. Record review of Resident # 6's care plan revised 7/16/2024 revealed the following care areas: *Resident # 6 has cellulitis wound to left great toe. Goal included: Resident # 6 wound will decrease in size as evidenced by wound documentation with no complications and comfort will be maintained. Interventions included: CNA to inspect skin, especially over bony prominences during bathing and personal care. Encourage fluids to maintain hydration. Wound care as ordered. Record review of Resident # 6's physicians orders for July 2024 revealed the following active medication orders: *Furosemide tablet; 20 mg; Give 1 tablet by mouth once a day (7:00 am-10:00 am) for localized swelling mass and lump limb bilateral. Record review of the facility's Medication Administration Compliance Report for 7/31/2024-8/2/2024 revealed for the following for Resident # 6: *Furosemide tablet- scheduled for 8:00 am and was administered at 11:53 am on 7/31/2024. Resident # 7 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 7's face sheet, undated, revealed he was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident # 7's diagnoses included: Pneumonia (infection that inflames air sacs in one or both lungs), Down Syndrome (a genetic chromosome 21 disorder causing developmental and intellectual delays), muscle weakness, muscle wasting and atrophy, dysphagia(difficulty swallowing), cognitive communication deficit, oropharyngeal phase(voluntary part of swallowing that moves food from the mouth to oropharynx, Generalized anxiety (intense, excessive, and persistent worry and fear), adjustment disorder (mental disorder) and developmental disorder(a group of conditions due to an impairment in physical learning, language or behavior areas). Record review of Resident # 7's MDS dated [DATE] revealed she sometimes made herself understood; there was no BIMS noted; never/rarely make decisions; needed some help self-care and indoor mobility; mobility device used wheelchair; supervision needed for eating; partial/moderate assistance needed for oral hygiene and upper dressing; substantial/maximal assistance needed for toileting, showering and bathing. Record review of Resident# 7's care plan revised 7/26/2024 revealed the following care areas: Resident # 7 has cognitive impairment r/t down syndrome and dementia. Goal included: Resident # 7 is at risk for adverse consequences R/T receiving antidepressant medication for treatment for Depression. Goal included: Resident # 7 will not exhibit signs of drug related side effects or adverse drug reaction thru the next review dates. Interventions included: Assess/record/effectiveness of drug treatment. Monitor and report signs sedation, hypotension, or anticholinergic symptoms. Ensure that consent is received prior to administering medication. Monitor resident's mood and response to medication. Administer medications as ordered per doctor. Record review of Resident # 7's physician orders for July 2024 revealed the following active medication: * Buspirone tablet; 7.5 mg- Give 1 tablet by mouth three times a day (7:00 am-9:00 am, 11:00 am-1:00 pm, and 4:00 pm-6:00 pm) for anxiety disorder, *Divalproex capsule, delayed release sprinkle; 125 mg- Give 2 capsules twice a day (7:00 am-10:00 am and 7:00 pm- 9:00 pm) for mood disorder, and *Escitalopram oxalate solution; 5 mg/5 ml; Give once a day (7:00 am-10:00 am) for anxiety. Review of the facility's Medication Administration Compliance Report for 7/21/2024-7/27/2024 revealed the following: * Buspirone tablet- scheduled daily at 8:00 am and was administered at 10:22 am on 7/26/2024, * Buspirone tablet- scheduled daily at 12:00 pm and was administered at 13:52 pm on 7/26/2024, * Buspirone tablet- scheduled daily at 4:00 pm and was administered at 5:43 pm on 7/26/2024, *Divalproex capsule-scheduled daily at 8:00 am and was administered at 10:22 am on 7/26/2024, and (continued on next page)

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	675214	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Escitalopram oxalate solution scheduled daily at 8:00 am and was administered at 8:00 am on 7/26/2024. Resident # 8 Record review of Resident # 8's face sheet, undated, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident # 8's diagnoses included: Unspecified dementia(a group of thinking and social symptoms that interferes with daily functioning), Vitamin D deficiency (lack of vitamin D from food and sunlight), Muscle spasm of back(a sudden, involuntary contraction of the back muscles), acute cough, muscle wasting and atrophy, generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), hypokalemia (low potassium), hypertension (high blood pressure), Alzheimer disease(a progressive disease that destroys memory and other important mental functions). Record review of Resident # 8's physician's orders for July 2024 revealed the following active medication orders: *Neurontin (gabapentin) capsule; 100 mg; Give 2 capsules daily by mouth three times a day (10:00 am, 3:00 pm, and 8:00 pm) for pain, unspecified. This medication was administered at 11:18 am on 7/31/2024. *Amlodipine tablet; 5 mg; Give 1 tablet by mouth once a day (10:00 am) for hypertension. This medication was administered at 11:18 am on 7/31/2024. *Memantine tablet; 10 mg; Give 1 tablet by mouth twice a day (10:00 am and 6:00 pm) for Alzheimer's disease. Resident # 9 Record review of Resident # 9's face sheet, undated, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident # 9's diagnoses included Parkinsonism (a clinical syndrome characterized by tremors), Type 2 diabetes (high sugar level), swelling, mass and lump lower, bilateral, and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of Resident# 9's MDS dated [DATE] he made herself understood; he had a BIMS score of 4 (severe cognitive impairment); he did not exhibit behaviors related to rejection of care; set and clean up assistance needed for eating; partial/moderate assistance needed for oral, toileting and personal hygiene, upper and lower body dressing; supervision needed for toilet transfer, shower and tub transfer. Record review of Resident # 9's care plan, revised 6/19/2024 revealed the following care areas: *Resident # 9 has Parkinson's disease. Goal included: Resident # 9 will remain free of major injuries thru the next review dates. Interventions included: Assure the floor is free of glare, liquids, foreign objects; keep bed in lowest position with brakes locked. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Resident # 9 has diabetes mellitus. Goal included: Resident # 9 will have absence of signs of hypoglycemia and hyperglycemia thru the next review dates. Interventions included: Administer medications as ordered by doctor; monitor blood glucose as ordered per doctor, *Resident # 9 is at risk for adverse consequence R/T receiving antipsychotic medication for treatment of schizoaffective disorder. Goal included: Resident # 9 will not exhibit signs of drug related side effects or adverse drug reaction. Intervention included: Administer antipsychotic as ordered per doctor; monitor resident's behavior and response to medication. Resident # 9 has a diagnosis of bipolar/depression. Goal included: Resident # 9 will have no unaddressed complications r/t Depression thru the next review date. Interventions included: Administer medication as ordered per doctor and monitor for adverse effects; ensure that consent is obtained prior to administering medication; monitor for side effects of antidepressant. Record review of physician's orders for July 2024 revealed active medications: *Carbidopa-levodopa tablet; 25-100 mg; Give one tablet three times a day (8:00 am, 12:00 pm and 4:00 pm) for Parkinsonism, *Furosemide tablet; 20 mg oral; Give two tablets in the morning and one tablet in the afternoon (7:00 am-10:00 am) for