STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675289	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azalea Heights	3505 Old Jacksonville Rd Tyler, TX 75701

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observation, interview and record review, the facility failed to provide the necessary services to maintain acceptable grooming and personal hygiene for 2 of 3 residents reviewed for ADLs (Resident's #1 and Resident #2). The facility failed to ensure Resident #1's received a bath until 5 days after his admission. The facility failed to ensure Resident #2 received a bath/shower for 4 weeks. This failure could place dependent residents at risk for poor personal hygiene, skin infections and decreased quality of life. Findings included: Record review of the face sheet dated 4/22/24 for Resident #1 indicated he was [AGE] years old, admitted to the facility on [DATE] with diagnoses including, Alzheimer's disease, high blood pressure, restlessness and agitation, anxiety disorder, heart disease, neuropathy (Weakness, numbness, and pain from nerve damage), visual hallucinations, major depressive disorder, agoraphobia (Fear of places and situations that might cause panic, helplessness, or embarrassment), and orthostatic hypotension (low blood pressure that happens when standing up from sitting or lying down). Record review of the MDS for Resident #1 dated 4/6/24 indicated he usually made himself understood and usually understood others. The MDS indicated Resident #1 had short-term and long-term memory problems. The MDS indicated he had severely impaired cognitive skills for decision machining. The MDS indicated he had no behavior of rejecting care. The MDS indicated he was dependent on staff for eating, oral hygiene, toileting, showers/bathing, dressing (both the upper and lower body), putting on footwear, and personal hygiene. The MDS indicated he was always incontinent of bowel and bladder. Record review of the care plan dated 4/2/24 indicated Resident #1 was at risk for self-care deficit. The care plan interventions included 2-person assistance with bed mobility, hygiene, transfers, and toileting. During an interview on 4/25/24 at 10:39 a.m., Resident #1's family member said she visited Resident #1 every day while he was in the facility. Resident #1's family member said he remained in the same clothes for the first 4 days he was in the facility (4/1/24 to 4/4/24) and did not think he had received a shower. (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: 675289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Azalea Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 3505 Old Jacksonville Rd Tyler, TX 75701	

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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 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Record review of Resident #1's ADL documentation did not indicate he had received a shower or bath from 4/1/24 to 4/5/24.

2. Record review of the face sheet for Resident #2 dated 4/26/24 indicated he was [AGE] years old, admitted to the facility on [DATE] with diagnoses including paraplegia (Paralysis that affects all or part of the trunk, legs, and pelvic organs), COPD (group of lung diseases that block airflow and make it difficult to breathe), artificial openings of the urinary tract status, colostomy (an opening in the large intestine, or the surgical procedure that creates one. The opening is formed by drawing the healthy end of the colon through an incision in the anterior abdominal wall and suturing it into place), and depression.

Record review of the MDS dated [DATE] for Resident #2, indicated he made himself understood and understood others. The MDS indicated he had no cognitive impairment (BIMS of 15). The MDS indicated he had no behavior of rejecting care. The MDS indicated Resident #2 required substantial/maximal assistance with toileting. The MDS indicated he was dependent on staff for shower/bathing.

During an observation and interview on 4/26/24 at 12:40 p.m., revealed Resident #2 laid in his bed. His hair appeared greasy. Resident #2 had a faint smell of body odor. Resident #2 said he had not received a shower or bed bath in 4 weeks. Resident #2 said he had not asked any staff about not receiving a bath or shower but knew he was supposed to receive them. Resident #2 said he felt staff had not provided him a shower because doing so was a bit of process. Resident #2 explained he had to be lifted from the bed with a mechanical lift and lowered onto a shower bed. Resident #2 said he felt staff just didn't want to go through the process of providing him a shower.

During an interview and observation on 4/29/24 at 9:35 a.m., Resident #2 laid in his bed. His hair appeared greasy. Resident #2 had a faint smell of body odor. Resident #2 said he had not received a shower or bed bath since 4/26/24. Resident #2 said his gown was changed but he was not given a shower. Resident #2 said he asked for a washcloth to wash his face and arm pits but was not provided one. Resident #2 said he did not know the name of the CNA he asked for a washcloth.

Record review of the ADL documentation for Resident #2 from 4/13/24 to 4/29/24 indicated he received a bath/shower on the following dates:

*4/27/24- documented by CNA L

*4/25/24- documented by CNA M

*4/20/24- documented by CNA N

*4/18/24- documented by CNA O

*4/16/24- documented by CNA P

(continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/24 at 1:26 p.m., CNA M said she did not give a bath or shower to Resident #2 on 4/25/24. CNA M said she was not even assigned to him on that day. CNA M said she gave her sign in information to agency staff so they could document and that was why the documentation reflected she had documented Resident #2 had received a bath on that day (4/25/24). CNA M said she could not remember the agency staff members name. CNA M said she had given her sign in information to multiple agency staff. During an interview on 4/29/24 at 2:37 p.m., CNA L said she had provided Resident #2 a bed bath when she worked on 4/27/24. CNA L said Resident #2 received a bed bath on 4/27/24 because he refused to a shower. An interview with CNA N regarding Resident #2 was attempted on 4/29/24 but was not completed due to no returned phone call. An interview with CNA O regarding Resident #2 was attempted on 4/29/24 but was not completed due to no returned phone call. An interview with CNA P regarding Resident #2 was attempted on 4/29/24 but was not completed due to no returned phone call. During an interview on 4/29/24 at 2:15 p.m., CNA L said it was important residents received scheduled bathing/showers in order to maintain hygiene and identify any skin changes. CNA L said the administration of showers/baths were documented in EMR record. During an interview on 4/29/24 at 2:17 p.m., LVN F said it was important for residents to receive showers/baths to ensure good hygiene and make the resident feel better. During an interview on 4/29/24 at 2:37 p.m., the DON said she expected CNAs to provide residents with showers/baths. The DON said it was important for residents to receive their showers/baths to promote hygiene. Record review of the facility policy and procedure titled Activities Daily Living revised January 2023 stated . each resident's abilities to perform activities of daily living will not diminish .Activities of daily living include: personal hygiene . The facility policy and procedure did not specifically address ensuring dependent resident received showering/bathing.

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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 - Minimal harm or potential for actual harm 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** 41093 Based on observation, interview and record review the facility failed to ensure each resident receives adequate supervision to prevent accidents for 1 of 2 residents reviewed for accident hazards (Resident #3). The facility failed to ensure Resident #3 had no history of elopement before accepting her as resident (the facility did not have a secure unit nor a wander guard system and thus would not accept residents with a history of elopement). The facility did not accurately assess Resident #3's physical ability to leave the facility upon her admission on 4/24/24. This failure could place residents with recent at risk for inadequate supervision elopement and significant injury. Findings included: Record review of the face sheet for Resident #3 dated 4/26/24 indicated she was [AGE] years old, admitted to the facility on [DATE] with diagnoses including Dementia, high blood pressure, atherosclerosis (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow), osteoporosis (A condition in which bones become weak and brittle) and high cholesterol. Record review of the baseline care plan for Resident #3 dated 4/24/24 indicated Resident #3 had a diagnosis of Dementia and would be provided care and safety checks throughout each shift. The care plan was updated on 4/25/24 and indicated Resident #3 was exit seeking and at risk for elopement and/or wandering with unsafe boundaries. The care plan indicated Resident #3 had a history of actual attempts to leave the facility unattended. The care plan interventions included 1 on 1 observation (1 staff member with the Resident at all times) until she could be transferred to a memory care unit. Record review of the nursing note dated 4/25/24 at 11:30 a.m. for Resident #3 indicated the nurse heard the D hall alarm go off the nurse responded to the alarm and saw Resident #3 walking across the parking lot. The nursing note indicated the nurse followed Resident #3 and asked her to come back to the facility but Resident #3 continued heading down the sidewalk when another employee joined her and was able to catch up to Resident #3. The note indicated the facility staff were able to convince Resident #3 to come back to the facility and call her family. The nursing note indicated upon return to the facility Resident #3 was placed on 1 to 1 observation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/26/24 at 1:00 p.m., RN A said Resident #3's elopement incident occurred early in the morning on 4/25/24 at approximately 7:45 a.m. RN A said she was at the nursing station when the D hall alarm went off. RN A said she went to the D hall exit door and looked outside and saw Resident #3. RN A said Resident #3 was approximately 20 feet from the exit door walking briskly and started across the parking lot. RN A said she just couldn't keep up with her and said she could not run to get her. RN A said she continued to follow Resident #3 across the parking lot when human resources staff E pulled into the parking lot. RN A said Resident #3 crossed the side street and started onto the sidewalk (across the side street from the facility). RN A said human resources staff E ran and got Resident #3 by the hand. RN A said human resources staff E stood talking with Resident #3 until she (RN A) could reach her (Resident #3). RN A said Resident #3 was then taken back into the facility. RN A said she immediately notified the DON who instructed her to ensure Resident #3 was placed on 1 to 1 observation. RN A said 1 to 1 observation meant a staff member was to stay with Resident #3 at all times and have no other assignment. RN A said she knew nothing of Resident #3's elopement history. During an interview on 4/26/24 at 1:10 p.m., human resources staff E said as she arrived to the facility at approximately 7:45 a.m. on 4/25/24, she saw Resident #3 walking across the parking lot. Human resources staff E said she was not sure at first that Resident #3 was a resident and thought perhaps she was just someone out walking, cutting across the parking lot. Human resources staff E explained Resident #3 was walking at a brisk pace and did not seem confused or lost. Human resources staff said as she pulled into her parking spot Resident #3 had crossed the side street and started onto the sidewalk. Human resources staff E said she saw RN A walking across the parking lot and asked her if the lady walking was a resident. Human resources staff E said RN A yelled Yes, and so she ran up to Resident #3 held her hand and started talking to her. Human resources staff E said RN A caught up to them and they took her (Resident #3) back into the facility. During an observation and interview on 4/26/24 at 1:40 p.m., Resident #3 said she just left the facility because she needed to call her family. Resident #3 sat smoking a cigarette in the smoking area with staff beside her. Resident #3 was asked again about leaving the facility and she said, Oh I don't know about that. During an interview on 4/26/24 at 2:09 p.m. Resident #3's family member #2 said she spoke with the admissions coordinator last Friday (4/19/24) and sent over all the necessary paperwork to have her admitted . Family member #2 said Resident #3 was admitted to facility in the afternoon on 4/25/24 but could not say exactly what time. Family member #2 said the facility contacted her on 4/26/24 and told her Resident #3 had eloped from the facility. Family member #2 said they were keeping someone with Resident #3 at all times and would do so until they could find a facility with a secure unit for her. During an interview on 4/26/24 at 2:13 p.m., Resident #3's family member said Resident #3 was admitted into the facility on [DATE] sometime after 1:30 p.m. in the late afternoon. Resident #3's family member said he had been contacted and told Resident #3 had eloped from the facility and that the facility was seeking out a home that could provide a secured unit for Resident #3. The family member said he understood the need for a secured unit and had no problem with the transfer but was a little frustrated because the whole reason the family sought long-term care was because Resident #3 had wandered off from her apartment and was found by the police. The family member said they (the family) was upfront with the facility and had told them of the event. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's admission paperwork found no documentation of elopement history or the incident described by Resident #3's family member in which she left her apartment and was found by police. During an interview on 4/26/24 at 3:20 p.m., admissions coordinator B said she had talked to the Resident #3's family member #2 last Friday (4/19/24) regarding an admission for Resident #3. Admissions coordinator B said when she spoke with family member #2, she told her the family was seeking admission into long term care because she (Resident #3) had reached a point she would call family members constantly and the care she needed was just too much for them. Admissions coordinator B said family member #2 said she/he worked during the day and could not check on Resident #3 as often was needed and could not take her calls as often as she would call. Admissions coordinator B said the family seemed to be in a rush to get her admitted and had all the necessary paperwork to them on Friday (4/29/24). Admissions coordinator B said the facility used a centralized admission process. She explained that once all the necessary paperwork was gathered it was sent to the company's central office for review. Admissions coordinator B said sometimes the central office will send back notes or conditions after reviewing the paperwork. Admissions coordinator B said for example a nurse may have to go out and evaluate the potential resident. Admissions coordinator B said this was not the case for Resident #3 as the central office had cleared her for admission. Admissions coordinator B said family member #2 said nothing to her about Resident #3 having eloped from her independent living apartment and being found by the police. Admissions coordinator B said the facility did not take Residents with a history of elopement. During an interview on 4/26/24 at 3:32 p.m., the DON said she knew nothing of Resident #3's history of elopement and there was nothing in the records received regarding a history of elopement. The DON said the facility simply would not have accepted Resident #3, had they known about the elopement history. The DON said the facility did not have a wander guard system nor a secured unit and therefore did not accept residents with an elopement history. The DON said the facility had secured placement for Resident #3 in a facility with a secured unit, but the facility could not take her until Monday (4/29/24). The DON said Resident #3 would remain on 1 on 1 observation until she was transferred to the facility with the secured unit. During an interview on 4/29/24 at 10:40a.m., Resident #1's family member said the family had decided Resident #3 needed to be placed in long term care because she had left her apartment and was found by the police on 4/18/24. The family member said Resident #3 lived independently in her apartment until that incident. The family member said the facility had been contacted regarding possible admission and all the required paperwork was sent 4/19/24. The family member said admissions coordinator B, business office manager C and social worker D all were aware of Resident #3's history of eloping from her apartment and being found by the police on 4/18/24. During an interview on 4/29/24 at 10:50 a.m., admissions coordinator B said she had spoken with family member #2 and it was never relayed to her that Resident #3 had eloped form her apartment. Admissions coordinator B said the facility just would not have taken her and had just denied someone placement last week because they had a history of elopement. During an interview on 4/29/24 at 10:55 a.m., business office manager C said the family had not told her anything about Resident #3's elopement history. Business office manager C said she had only discussed financial aspects and payor sources with the family as that was what her job entailed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/29/24 at 11:04 a.m., social worker D said the family had not said anything to her about Resident #3 having a history of elopement. Social worker D said she helped the family complete a DNR and completed PASRR paperwork and the family never mentioned Resident #3 had left her apartment and was found by police. Record review of the admission assessment dated [DATE] at 4:08 p.m. section L Exit seeking tool, indicated Resident #3 did not have the physical ability to leave the building on her own. This section of the admission assessment had no further assessment questions answered as the tool stated . (1) Is the resident physically able to leave the building on their own? If no, disregard remaining questions. This assessment was completed by LVN F. During an interview on 4/29/24 at 1:30 p.m., ADON G said she could not say why LVN F would have marked no on the admission assessment, as Resident #3 had the physical ability to leave the building but said she did not feel this assessment would have prevented Resident #3 from eloping the facility. ADON G said the remaining questions on the exit seeking tool if the question, Is the resident physically able to leave the building on their own? was marked yes asked about wandering, wandering history, exit seeking, exit seeking history, and the display of behaviors related to wandering and exit seeking. ADON G said at the time the assessment had been completed Resident #3 had been in the facility a few hours and Resident #3 had not displayed any of those behaviors. The ADON said she knew nothing of Resident #3's elopement history. ADON G said the facility does not accept resident with exit seeking behavior. During an interview on 4/29/24 at 1:35 p.m., the DON said Resident #3 had been transferred to a facility with a secured unit. The DON said she had always taken the question on the admission assessment under section L Exit seeking tool to mean would the resident leave the building on their own. The DON said after re-reading the question she understood the question to ask whether or not a resident had the physical ability to leave the building. The DON said she did not feel the assessment would have prevented Resident #3's elopement from the building. She said the remaining questions on the exit seeking tool if the question, Is the resident physically able to leave the building on their own? was marked yes asked about wandering, wandering history, exit seeking, exit seeking history, and the display of behaviors related to wandering and exit seeking. The DON said at the time the assessment had been completed Resident #3 had been in the facility a few hours and Resident #3 had not displayed any of those behaviors. The DON said she knew nothing of Resident #3's elopement history. The DON said had she have known Resident #3 had a history of elopement the facility would have not accepted her. During an interview on 4/29/24 at 2:17 p.m., LVN F said she marked no on the admission assessment under section L Exit seeking tool because she understood the question to mean would the resident leave the building on their own. LVN F said Resident #3 had been in the facility a few hours but had not displayed any exit seeking behaviors and was content in her room when she cared for her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy and procedure revised January 2023, titled Elopement Response & Exit Seeking Management stated, .A. Elopement Response: Unable to locate resident (1) If a resident is unable to be located or the alarms have sounded, immediately initiate a search of the entire community both inside and outside premises B. Response following the location of the resident: (1) Once located and safety confirmed, conduct an assessment. (2) Place resident on enhanced monitoring, consider 1:1 for a specified time as needed to ensure the safety of resident or consider placement in secured unit for continued monitoring and safety. The facility policy and procedure did not detail the facility would not accept Resident's with a history of elopement. During an interview on 4/29/24 at 2:20 p.m., the corporate RN said the facility did not have a policy and procedure that specifically addressed the accurate completion of admission assessments or regarding the centralized admission process. Record review of the facility policy and procedure revised January 2023, titled Professional Standards of Care, stated, .Nurses should conduct assessments or evaluations and document nurses' notes in the following instances: 1) routine charting for residents should reflect the recipient's ability as assessed upon admission, re-admission and as clinically indicated; and 2) at the time of accidents, incidents or change in condition. All exceptions to stable, baseline or usual status should be recorded as exceptions and included in the clinical record .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on interviews and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate monitoring) for 1 (Resident # 1) of 4 residents whose medications were reviewed for pharmacy services. The facility failed to ensure Resident #1 was consistently and adequately monitored for adverse side effects of Lorazepam (medication used to treat anxiety, lorazepam belongs to a class of drugs known as benzodiazepines which act on the brain and nerves [central nervous system] to produce a calming effect). This failure could place residents at risk of possible medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: Record review of the face sheet dated 4/22/24 for Resident #1 indicated he was [AGE] years old, admitted to the facility on [DATE] with diagnoses including, Alzheimer's disease, high blood pressure, restlessness and agitation, anxiety disorder, heart disease, neuropathy (Weakness, numbness, and pain from nerve damage), visual hallucinations, major depressive disorder, agoraphobia (Fear of places and situations that might cause panic, helplessness, or embarrassment), and orthostatic hypotension (low blood pressure that happens when standing up from sitting or lying down). Record review of the MDS for Resident #1 dated 4/6/24 indicated he usually made himself understood and usually understood others. The MDS indicated Resident #1 had short-term and long-term memory problems. The MDS indicated he had severely impaired cognitive skills for decision machining. The MDS indicated he had no behavior of rejecting care. The MDS indicated he had no indicators of psychosis and displayed no physical or verbal behaviors towards others or himself. The MDS indicated he was dependent on staff for ADLS. Record review of the care plan dated 4/2/24 indicated Resident #1 required the use of anti-anxiety medication, the care plan interventions included administer medications per MD orders, monitor/document/report to the MD any adverse reactions to anti-anxiety therapy (drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion, disorientation, depression, dizziness, lightheadedness, impaired thinking, and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision) or unexpected side effects (mania, hostility, rage, aggressive or impulsive behavior, hallucinations). Record review of Resident #1's physician order dated 4/1/24 indicated he was to be administered Lorazepam Oral Tablet 0.5 MG by mouth at bedtime for anxiety hold for sedation. This order was discontinued on 4/10/24. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's physician order dated 4/2/24 indicated Resident #1 was to be monitored for the following Antianxiety Side Effects Monitoring: sedation/drowsiness, increased falls/dizziness, hypotension, anxiety/agitation, blurred vision, sweating/rashes, weakness, headache, dystonia, urinary retention/hesitancy, anticholinergic symptoms, cardiac abnormalities, hangover effect. The order indicated any other side effects noted should be documented in a progress note. This order was discontinued on 4/10/24. Record review of Resident #1's physician order dated 4/10/24 indicated he was to be administered Lorazepam Oral Tablet 0.5 MG by mouth three times a day for anxiety hold for sedation. This order was discontinued on 4/14/24. Record review of Resident #1's physician order dated 4/14/24 indicated he was to be administered Lorazepam Oral Tablet 0.5 MG by mouth two times a day for anxiety hold for sedation. This order was discontinued on 4/18/24. Record review of Resident #1's physician order dated 4/18/24 indicated he was to be administered Lorazepam Oral Tablet 0.5 MG by mouth at bedtime for anxiety hold for sedation. This order was discontinued on 4/23/24. Record review of Resident #1's MAR for April 2024 indicated he had been administered his Lorazepam as ordered by the physician from 4/1/24 to 4/18/24. Record review of the MAR indicated Resident #1 was monitored for the following Antianxiety Side Effects Monitoring: sedation/drowsiness, increased falls/dizziness, hypotension, anxiety/agitation, blurred vision, sweating/rashes, weakness, headache, dystonia, urinary retention/hesitancy, anticholinergic symptoms, cardiac abnormalities, hangover effect, from 4/2/24 to 4/10/24. The MAR did not indicate Resident #1 was monitored for the antianxiety side effects from 4/11/24 to 4/19/24. Record review of Resident #1's nurse's notes dated 4/11/24-4/13/24 found the following documentation related to antianxiety side effects monitoring: *4/11/24 at 3:00 a.m., no adverse effects of lorazepam *4/12/24 at 1:39 a.m., no adverse effects of lorazepam *4/13/24 - no notes related to antianxiety side effects monitoring were documented Record review of Resident #1's nursing note dated 4/14/24 at 1:34 p.m., stated .resident responding to verbal and physical stimuli very slowly. Resident family requesting that Ativan (brand name for lorazepam) be put on hold until resident is more alert. Notified MD .received new order . Record review of Resident #1's nurse's notes dated 4/15/24-4/17/24 found the following documentation related to antianxiety side effects monitoring: *4/15/24 - no notes related to antianxiety side effects monitoring were documented *4/16/24- no sedation noted (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Azalea Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 3505 Old Jacksonville Rd Tyler, TX 75701	

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*4/17/24- no notes related to antianxiety side effects monitoring were documented Record review of Resident #1's nursing progress note dated 4/18/24 at 1:34 p.m., indicated an order for all psychotropic medications to be put on hold had been obtained due to lethargy. During an interview on 4/24/24 at 12:14 p.m., LVN J said she took care of Resident #1 regularly. LVN J said she took care of Resident #1 on 4/13/24. LVN J said there were a lot of changes with Resident #1's lorazepam. LVN J said nurses should assess residents on antianxiety medications at least once a shift and document on the MAR. LVN J said there was a place to document antianxiety side effects monitoring on the MAR. LVN J said it would be especially important to assess/document for antianxiety side effects monitoring for residents having changes in dosage like Resident #1. LVN J said if for some reason the antianxiety side effects monitoring was not on the MAR the nurse should document the antianxiety side effects monitoring on a nursing progress note. LVN J said she had not realized she had not documented antianxiety side effects monitoring for Resident #1 on 4/13/24. LVN J said she did document when Resident #1 was found over sedated and notified the MD on 4/14/24. LVN J said Resident #1 was not over sedated on 4/13/24 or she would have documented and notified the MD at that time. During an interview on 4/24/24 at 1:26 p.m., LVN K said she took care of Resident #1 on 4/17/24. LVN K said there was a place to document antianxiety side effects monitoring on the MAR. LVN K said it would be especially important to assess/document for antianxiety side effects monitoring for residents having changes in dosage like Resident #1. LVN K said if for some reason the antianxiety side effects monitoring was not on the MAR, she would document the antianxiety side effects monitoring on a nursing progress note. LVN K said she had not realized she had not documented antianxiety side effects monitoring for Resident #1 on 4/17/24. During an interview on 4/24/24 at 1:30 p.m., ADON I said he had spoken to the MD and received the order for the increase of Resident #1's lorazepam on 4/10/24. ADON I said he had dc'd the old order for the lorazepam but did not realize the side effect monitoring was dc'd at the time. ADON I said it was important to monitor residents on antianxiety medications especially after an increase in dosage to ensure they were not overly sedated or experiencing any adverse effects. ADON I said he wasn't sure if he had to enter the monitoring as a separate order or if it was coupled with lorazepam order. During an interview on 4/24/24 at 3:30 p.m., the DON said she expected nurses to monitor and document for adverse effects/side effects of antianxiety medications at least once a shift. The DON said she did not understand how the antianxiety side effect monitoring was removed from Resident #1's MAR. The DON said antianxiety side effect monitoring should have remained on the MAR the entire time Resident #1 was on the antianxiety medication. The DON said it was especially important for antianxiety side effect monitoring to be performed with the increase in dosage Resident #1 was ordered. The DON said there had not been a specific system in place to ensure nurses were monitoring/documenting for psychotropic adverse/side effects prior to 4/19/24. The DON said she was know monitoring resident's receiving psychotropic medications weekly to ensure they received appropriate monitoring. A facility policy and procedure regarding the monitoring residents on psychotropic medications was requested but not received.