STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675445	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flatonia Healthcare Center	624 N Converse St Flatonia, TX 78941

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen.1. The facility failed to properly store raw chicken in its kitchen on 12/02/2025.2. The facility failed to properly store, label, and date all food items located in the facility refrigerators, freezers and in the dry food pantry area on 12/02/2025, 12/03/2025 and 12/04/2025. 3. The facility failed to discard outdated food items located in the refrigerator on 12/02/2025,12/03/2025, and 12/04/2025. 4. The facility failed to ensure the first upright kitchen freezer maintained a safe storage temperature and did not allow food items to thaw.These failures could place residents who received meals from the kitchen at risk of foodborne illnesses. Observation during the initial tour of the kitchen on 12/02/2025 beginning at 8:54 AM revealed the following:1 silver pan containing raw chicken sitting on dish sanitizing area.Refrigerator:1 pan of cooked ground taco meat dated 11/28/2025, no discard/use by date1 storage bag of cooked hamburger patties dated 11/29/2025, no discard/use by date1 storage bag of cooked pork dated 11/30/2025, no discard/use by date3 opened gallon containers of salad dressings, no discard dates. One was marked 9/4/2025, one marked opened 11/21/20251 carton of chicken broth opened 11/26/2025, no discard date.1 opened storage bag of honey ham, marked 11/30/2025, no discard date1 opened bag of turkey breast dated 1 opened bag of sliced cheese dated 11/29/2025, no discard date1 silver pan covered with foil marked tomatoes and lettuce for hamburgers dated 11/30/2025, no discard/use by date1 storage bag of tator tots, not labeled or dated1 storage bag marked hamburger meat dated 12/1/25, no discard/use by dateFreezer 1:Observed 4 storage bags opened out of their original packaging, no labels or dates.Freezer 2:Observed to have a temperature of 38 degrees1 storage bag marked churros with date of 11/11/25, do discard date, item was thawing3 bags of thawing Brussel sproutsStorage bag of about 12 thawing sherbertsDry Food Pantry area:Opened Hawaiian rolls placed in storage bag dated 11/26/2025, no discard date1 opened hamburger buns, no open or discard date.1 opened package of muffin mix dated 4/12, no discard date1 opened package of corn meal with a date of 11/11/25, no discard/use by date1 opened bag of flour, no open date or discard date1 opened bag of instant potatoes, no discard/use by date1 opened pancake mix, no discard/use by date3 opened cake mixes, no discard/use by dates1 opened bag of grits, no discard/use by dates1 large container of macaroni, no discard/use by dates1 large container of corn meal, marked 9/23/25 no discard/use by datesObservation and interview conducted 12/2/2025 at 3:03 PM. Observed freezer 2 at 38 degrees, the temperature should be zero degrees Fahrenheit to 18 degrees Celsius. Dietary Manager was asked did she know the temperature was not correct for the freezer. Dietary Manager stated she noticed the sherbert thawing and the Brussel sprouts were thawed out. Dietary Manager stated she threw out the Brussel Sprouts and she is checking the temperature. Surveyor advised her the temperature is the same as it showed in the morning. Dietary manger stated a box was blocking an area in the freezer this morning and she is trying to see if it cools down, she stated they check the temp in the morning, mid day, and in the evening and record on the log. Surveyor advised Dietary Manger surveyor will need to notify ADM as the new delivery is being placed in the freezer.On (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	have staff remove any personal food items from the memory care refrigerator.Interview conducted with the Kitchen Aide on 12/04/2025 at 2:11 PM. The Kitchen Aide stated she has been employed at the facility for one year and four months. She stated she was initially trained by the previous Dietary Manager, and there have been four other managers since that time. The Kitchen Aide stated all staff are responsible for labeling and dating food items. She reported staff are expected to write the date received, the date opened, and the discard date, which is three days after the product is opened. The Kitchen Aide stated the potential harm that could occur if food is not discarded properly is that a resident could become very sick.Interview conducted with the Dietary Manager on 12/04/2025, at 2:18 PM. Dietary Manger stated she started in June with the facility. Dietary Manager reported that food items are labeled with the date received, and once they are opened, they are labeled with the open date but not always a discard date. Dietary Manger stated everyone knows the opened food is to be discarded in 3 days, she stated they rarely have leftovers that stay after 3 days. Surveyor showed her leftover food items that remained in the refrigerator that were not discarded, Dietary Manager stated the items should have been discarded, and she would throw them out. When asked about storage of thawing meats, the Dietary Manager stated items are placed in a container on the bottom shelf of the refrigerator. When provided an example of chicken thawing in a sink area, she explained that thawing chicken should be in the refrigerator. The surveyor advised her of the thawed chicken that was observed sitting out on 12/02/2025. The Dietary Manager acknowledged the item was not stored properly. Dietary manager acknowledged they would notify maintenance right away if the temperatures on the refrigerator and freezers are not properly working. Dietary Manager stated the potential harm that could occur if food is not properly stored under correct temperatures, label, dated, and discarded properly, is that residents could become very sick. Interview conducted with CNA F on 12/04/2025 at 3:53 PM. CNA F stated she has been employed at the facility since March or April. She reported she does not remember if she was trained on the facility's outside food policy. CNA F stated staff are expected to label food items brought in by family members with the date and time the item was brought in and, if opened, a discard date of three days. She stated that if a perishable item is brought in unopened, staff will still discard it after three days.Interview conducted with the DON on 12/04/2025, at 5:45 PM. The DON stated all food items should be labeled with date received, date opened, and a discard date of 3 days. The DON stated the teas and juices should be labeled with the date and time, and discard after use. The DON stated not properly labeling and discarding food timely could lead to potential problems, and residents could become ill.Interview conducted 12/04/2025, at 6:05 PM, the ADM stated that all food items should be labeled each time they are opened with a sticker showing the date opened, expiration date, and name of the product. The ADM stated that all expired food should be discarded immediately. She acknowledged that if expired food is served, residents could potentially experience negative side effects such as stomach aches or illness. The ADM stated raw chicken should not be sitting out, she stated it should be at the bottom of the refrigerator. She stated it could lead to e coli and cause residents to become very ill.Record review of the facility's policy named Preventing Foodborne Illness-Food Handling revealed:Policy Statement Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized.1. This facility recognizes that the critical factors implicated in foodborne illness are:a. Poor personal hygiene of food service employees;b. Inadequate cooking and improper holding temperatures;c. Contaminated equipment; andd. Unsafe food sources.2. With these factors as the primary focus of preventative measures, this facility strives to minimize the risk of foodborne illness to our residents.3. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents.Record review conducted 12/04/2025 of facility policy named Refrigerators and Freezers revealed:1. Acceptable temperature ranges are 35 F to 40 F for refrigerators and less than 0 F for freezers.2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures.3. Monthly (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	tracking sheets will include time, temperature, initials, and action taken. The last column will be completed only if temperatures are not acceptable.4. Food Service Supervisors or designated employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening.5. The supervisor will take immediate action if temperatures are out of range. Actions necessary to correct the temperatures will be recorded on the tracking sheet, including the repair personnel and/or department contacted.6. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened.7. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes.Record review 12/04/2025 of facility policy named Food receiving and Storage revealed:Policy Statement Foods shall be received and stored in a manner that complies with safe food handling practices.8. Dry foods that are stored in bins will either be removed from their original packaging, placed in a clean and dry bin, labeled and dated, or left in its original packaging with the proper date on the packaging. 9. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).10. Refrigerated foods must be stored below 41ˆF unless otherwise specified by law.11. Refrigerated foods will be stored in such a way that promotes adequate air circulation around food storage containers. Refrigerators/walk-ins will not be overcrowded.12. The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thawing.13. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements.14. Uncooked and raw animal products, including raw eggs) and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods.15. Food items and snacks kept on the nursing units must be maintained as indicated below:All food items to be kept below 41ˆF All foods belonging to residents must be labeled with the resident's name, the item and the use by date. Refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines. Beverages must be dated when opened and discarded after twenty-four (24) hours.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to prepare food by methods that conserve nutritive value and flavor for 1 kitchen reviewed for food and nutrition services.The facility failed to ensure [NAME] A refrained from adding an unmeasured amount of liquid to country pork tips with gravy, parslied noodles, and herb butter roll pureed meals during lunch service on 12/03/2025.This failure could place residents who received a pureed diet at risk for diminished or altered nutritional status and potential weight loss.Observation and interview on 12/03/2025, at 11:09 AM, revealed [NAME] A poured an unmeasured amount of milk into the parslied noodles without measuring after mixing one time, [NAME] A added another unmeasured amount of milk. [NAME] A was then observed preparing 3 herb butter rolls, adding an unmeasured amount of milk. Followed by [NAME] A adding an unmeasured amount of milk 3 different times to 3 large spoons of country pork tips. The mixture did not resemble the color of pork. When she was done, the pork appeared as a loose milky white mixture. [NAME] A was asked how much liquid was used per serving, she responded she did not know how much was used. [NAME] A stated, I just eyeball it, we do not have measuring cups. Surveyor asked to see recipe book, and the Dietary Manager brought it over. Dietary Manager mentioned the recipe book was used here and there with certain recipes. Surveyor asked [NAME] A if she used the recipe book, she stated she only referred to the recipe when she had questions. The recipe book showed the parslied noodles to require only 1/8 teaspoon of liquid per 1/3 cup serving. The country pork tips called for 0.5 ounce of liquid per 1/3 cup serving. The recipe book showed the meat should be pureed with broth, or other appropriate sauce/gravy from menu.A Test tray was requested and received on 12/03/2025 at 12:40 PM. The meal served was country pork tips with gravy, parslied noodles, green beans, and roll. The test tray was received for a regular texture diet. The parslied noodles had no flavor; the pork tips had a little flavor but had a few tough meat areas.A follow up interview was conducted with [NAME] A on 12/03/2025, at 1:18 PM. [NAME] A stated she had been employed at the facility for five months. [NAME] A stated she was trained by [NAME] B on pureed diets when she started at the facility. [NAME] A stated she did not use the recipe book often, and confirmed she was being honest about this. She reported that after she pureed the pork tips, she realized when surveyor asked the question about the liquids used, she could have used gravy instead of milk. [NAME] A stated she had not been trained on following recipes. [NAME] A stated that most of the time she looks up recipes online or asks the manager for assistance. She reported the kitchen does not have any measuring cups, so she eyeballs the amounts used in recipes. [NAME] A stated a dietitian recently came by to sample the pureed foods. She also stated another dietary manager from [NAME] comes to the facility to provide training as needed. [NAME] A reported that she and the current kitchen manager started working at the facility at the same time. [NAME] A stated she has always been told to use milk to puree foods, except for vegetables, for which she was instructed to use broth. [NAME] A was asked what potential harm could occur if she does not follow the recipes. [NAME] A stated the flavor of the food may change. She stated she does not know of any other harm that may be caused. [NAME] A stated When asked about potential effects of not following the recipe, [NAME] A stated it could change the flavor of the food and potentially create chewing issues, choking hazards, or risk of aspiration for residents.Interview conducted with the Dietary Manager on 12/04/2025, at 2:18 PM. Dietary manager stated she was unsure whether the cooks had been properly trained in preparing diet textures, as the cooks were employed at the facility prior to her assuming the role of Dietary Manager. Dietary Manger stated she started in June with the facility. She stated she understood she is responsible for enforcing kitchen procedures but reported she is still learning the facility's processes while completing her dietary management training. Dietary Manager stated she receives assistance from a Dietary Manger at a sister facility who comes to the facility to work with her on procedures. She stated that going forward, the Dietary Manager will be responsible for training (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	all dietary staff. The Dietary Manager stated she had been trained that liquids other than milk may be used to puree foods. When asked why the facility's recipe books were not consistently followed by staff, the Dietary Manager stated she personally follows the recipe books and reported that the other cooks had been at the facility before her. When asked how cooks verify portion sizes and measurements when preparing food according to recipes, the Dietary Manager stated that staff use measuring cups for accuracy. The Dietary Manager stated the kitchen plans to add broth and gravy into pureed meat recipes to enhance flavor. She stated the potential risk of harm from not following recipes includes food lacking flavor, which may result in residents losing their appetite and could contribute to weight loss.Interview conducted with the DON on 12/04/2025, at 5:45 PM. DON was asked, how are physician-ordered diets (such as pureed diets) communicated to nursing and dietary staff. DON stated they are put on a diet communication form and sent to the kitchen. DON was asked what systems are in place to ensure residents consistently receive the prescribed diet texture, she responded that the tray ticket and food are checked by the nurse before being given to the residents. DON stated they have a dietician that comes often to complete assessments. When asked if she knew what should be used to puree food, she stated she was unsure. DON stated she expects the dietary department to follow the recipes. When asked what could happen if the puree diet recipe was not followed, she stated that residents could potentially not receive the right amount of nutrients or lose calories if too much liquid was used. DON stated the residents can lose weight; muscles could deteriorate and could lead to possible death. DON also added that the taste and nutritional value of the food may be affected.Interview conducted with the ADM on 12/04/2025, at 6:05 PM, ADM stated her expectation was for dietary staff to follow the recipes as written. She stated they have measuring cups in the kitchen. ADM explained that if the pureed diet was not prepared according to the recipe, the food could lose its flavor and not taste good. She stated the potential harm to residents was that they may not receive the correct caloric intake and the resident could lose weight. ADM stated the pureed diet should be of a pudding, consistency and if the resident received the wrong texture they could aspirate.Interview conducted with [NAME] B on 12/04/2025, at 6:23 PM. [NAME] B stated she has worked at the facility for almost two years. [NAME] B stated she was trained on puree diets by a previous dietary manager. [NAME] B stated she trained [NAME] A when she first started at facility. [NAME] B stated she followed the recipe book, and she use the measuring cups for milk. [NAME] B stated she was taught only to use milk to puree food as it contains protein. [NAME] B stated using too much liquid could take away the flavor and the residents may not want to eat their food. [NAME] B stated if the resident did not eat their food, they could lose weight and possibly get sick.Record Review of the facility's diet order, conducted on 12/03/2025, revealed there were 3 residents on pureed diets. A facility pureed diet policy was requested from ADM on 12/04/2025 at 1:50 PM, the policy was not received at time of exit.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to treat each resident with respect and dignity and failed to provide care for each resident in a manner and environment that promoted the maintenance or enhancement of quality of life for 2 (Resident #12, Resident #17) of 10 residents reviewed for dignity.The facility failed to ensure that Resident #12 and Resident # 17 were provided dignified and individualized feeding assistance during the lunch meal on 12/02/2025.This failure could place residents at risk of diminished dignity and negatively affect their quality of life. Record review of Resident #12 Face sheet dated 12/03/2025, reflected she was a [AGE] year-old female, who was admitted to facility on 03/08/2025 with diagnoses of unspecified dementia (memory loss), major depressive disorder unspecified (feel sad, hopeless), and anxiety disorder. Record review of Resident # 12's MDS assessment, dated 10/31/2025, reflected she had a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. Record review of Resident # 12's care plan, dated 12/03/2025 reflected Feeding Assistance: Supervision with 1 person and Resident has a swallowing problem related to dementia, Caregiver training on proper positioning, cueing and device use during meals for maximization of po intake and safe po.Record review of Resident #17's Face sheet dated 12/02/2025, reflected he was a [AGE] year-old male, who was admitted to facility on 06/11/2025 with diagnoses of unspecified dementia (memory loss),acute respiratory failure with hypoxia (lungs can't get enough oxygen in the blood), metabolic encephalopathy (brain dysfunction due to internal metabolic issues), and critical illness myopathy (severe muscle weakness), dysphagia (swallowing disorder), and mood disorder.Record review of Resident # 17's MDS, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) was not conducted. The Staff Assessment for Mental Status revealed 3 indicating severely impaired cognition (never/rarely made decisions).Record review of Resident # 17's care plan dated 12/02/2025 reflected resident has a swallowing problem, and he should be monitored during meals for choking, holding food in mouth, several attempts at swallowing and appears concerned during meals.Observation of the facility's dining room on 12/2/2025 between 12:00 PM and 12:54 PM, revealed that at 12:26 PM, Resident #12 and Resident #17 were being fed their lunch meal at the same time by CNA C. CNA C did not wash her hands, nor did she use any hand sanitizer at the table between the two residents. Continued observation on 12/2/2025 at 12:40 PM revealed CNA C picked up Resident #17's cornbread with her bare hand and placed it on the table in front of him. CNA D signaled to CNA C the procedure was incorrect. CNA C then picked the cornbread back up from the table and placed it back on plate. CNA C proceeded to feed the cornbread to the resident directly from her fingers. CNA C would feed one, then switch to the other resident she did not engage in communication with Resident #12 and Resident # 17. She continued the process until both had finished their meal. Interview conducted 12/04/2025, at 3:30 PM, revealed CNA C had been a certified nursing assistant for a few months at the facility. CNA C stated she has been trained on the facility's abuse and neglect, resident rights, and promoting/maintaining resident dignity procedures. She provided examples of each. CNA C revealed she was aware residents had the right to be treated with dignity and respect during meals. She stated she had been instructed to feed one resident at a time. However, on the day of the incident, 12/02/2025, she sat between two residents and fed both at the same time. CNA C was asked if residents have the right to eat in a safe environment. She stated, ?Yes.' When asked if a resident could potentially aspirate or choke while staff assisted another resident, she stated, yes.' CNA C stated it would be considered a failure to provide a safe environment. CNA C was asked how residents might feel if they must wait with food in front of them while the CNA assisted another resident. She stated they would ?probably feel horrible and anxious.' CNA C stated she realized what she did was wrong.Interview conducted 12/04/2025 at 5:18 PM, with CNA D revealed she worked as a CNA for 15 years. CNA D stated she was trained on (continued on next page)

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	675445	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flatonia Healthcare Center	624 N Converse St Flatonia, TX 78941

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident rights and dignity. CNA D stated it was not appropriate to feed two residents at the same time. CNA D stated a facility staff could accidentally use the same feeding utensils for both residents, which would create a cross-contamination issue as well as a dignity concern. CNA D stated she witnessed the incident involving Resident #12 and Resident #17 being fed at the same time. She also stated she tried correcting CNA C about the cornbread. Interview conducted 12/04/2025 at 5:45 PM, the DON stated she was trained on resident rights, abuse and neglect and the facility's dignity policy. She stated herself and the ADM streamlined learning for the CNAs on dignity. The DON stated the ADON, herself, and CNA instructor trained the CNAs on meal assistance. The DON was asked if she considered it a rights and dignity concern if two residents were being fed at the same time by one CNA. The DON stated, yes, it could make the residents feel ignored. DON stated residents should have the right to a safe environment during mealtimes. The DON stated aspiration, or choking could be a potential accident, she also stated one resident could be giving the other residents' spoon which would create another issue. The DON stated staff needed to focus on one resident if they required feeding assistance. When asked about residents' right to a safe environment during mealtimes, the DON stated feeding two residents at the same time had infection control implications and could also be a safety concern. She explained that if a resident choked or aspirated while staff assisted another resident, it posed a safety risk. Additionally, she stated residents may feel unloved, uncared for, or extremely frustrated if they must wait for assistance while food sat in front of them.Interview conducted 12/04/2025 at 6:05 PM, the ADM stated the administrator and the DON were responsible for training staff on resident rights and dignity policies. The ADM stated the DON trains the CNAs on meal assistance. The ADM stated she feels feeding two residents at the same time violates their right to be treated with dignity and respect during meals. The ADM stated that potential harm could occur if attention is not paid to one resident while the staff looks away to the other resident, she stated a resident could still be chewing his or her food and possibly aspirate or choke. The ADM stated a resident could feel neglected if food just sat in front of them while they waited for assistance. The ADM stated she once was a CNA for 12 years; she was taught a tray is not supposed to be placed in front of a resident until someone is ready to feed them.Record review of the facility's policy on Resident Rights, dated February 2021, stated: Policy StatementEmployees shall treat all residents with kindness, respect, and dignity.Policy Interpretation and Implementation1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to:1. a dignified existence2. be treated with respect, kindness, and dignity3. be free from abuse, neglect, misappropriation of property, and exploitation

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of 5% or greater. There were two (2) medication errors in 26 opportunities for an error rate of 7.69% by 1 of 3 staff members observed (LVN) administering medications to 1 of 7 residents. (Resident #28). LVN attempted to administer Resident #28 Potassium Chloride Extended Release Oral Capsule Extended Release 10 milliequivalents, crushed with pudding. Order stated, Potassium Chloride ER Oral Capsule Extended Release 10 MEQ (Potassium Chloride) Give 1 capsule by mouth two times a day for supplement do not crush, may dissolve in 4-6oz (ounces) of water. Medication was attempted to be administered in the incorrect dosage form. LVN administered hydroCHLOROthiazide Oral Tablet 25 MG (milligrams). The order stated, hydroCHLOROthiazide Oral Tablet 25 MG (Hydrochlorothiazide) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION HOLD IF SBP (systolic blood pressure) IS < (greater than)110 [millimeters of mercury], AND DBP (diastolic blood pressure) IS < (less than) 50 [millimeters of mercury] OR HR (heart rate) < (less than) 60 [beats per minute] NOTIFY MD (medical director). Medication was administered without a blood pressure or pulse reading assessed prior to the administration of the medication per the physician order. This failure could place residents at risk of not receiving medications as ordered and not receiving therapeutic benefits. Findings include: Record review of Resident #28's Face sheet dated 12/03/2025 reflected a [AGE] year-old female, admitted to the facility on [DATE]. Diagnoses included dementia, dysphagia (difficulty swallowing), and hypertension (high blood pressure). Record review of Resident #28's Quarterly MDS (minimum data set) assessment dated [DATE] reflected she was rarely or never understood. Dysphagia (difficulty swallowing) was listed as an active diagnosis. She was dependent on staff for eating and received speech therapy for eating or swallowing for 7 days of the previous review period. Record review of Resident #28's physician orders reflected an order for hydrochlorothiazide oral tablet 25 mg with a start date of 10/24/2024. The directions for the order reflected, Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION HOLD IF SBP (systolic blood pressure) IS < (greater than)110 [millimeters of mercury], AND DBP (diastolic blood pressure) IS < (less than) 50 [millimeters of mercury] OR HR (heart rate) < (less than) 60 [beats per minute] NOTIFY MD (medical director). There was another order for potassium chloride extended release capsule with a dose of 25 mg. The directions reflected, Give 1 capsule by mouth two times a day for supplement do not crush, may dissolve in 4-6oz (ounces) of water. Record review of Resident #28's blood pressure reflected her last blood pressure was taken on 11/14/2025 at 9:22AM and was 118/71 mmHg (millimeters of mercury). Record review of Resident #28's blood pressure reflected her last pulse rate was taken on 11/14/2025 at 9:22AM and was 74 beats per minute. Record review of Resident #28's Progress Notes dated 11/03/2025 to 12/04/2025 reflected no hospitalizations or episodes of low blood pressure. Observation of medication administration on 12/03/2025 at 9:22AM with LVN G revealed she dispensed the medications for Resident #28 appropriately and crushed them to mix with pudding. There was no blood pressure or pulse taken for Resident #28 during the observation process. The administration process was interrupted prior to resident receiving the medications. In an interview with the CMA H, she stated that she should not have crushed the potassium chloride. She stated that per the orders, she should have dissolved it in water. She stated that Resident #28 was able to swallow thin liquids. She stated that the impact to the resident of not administering it in the correct form could be that the medication might not work as well. She wasted the medications per the facility policy and administered the potassium chloride dissolved in 6 ounces of water. Observation and interview with LVN G on 12/03/2025 at 10:38AM revealed that Resident #28's blood pressure was 140/94 mmHg and pulse was 89 beats per minute. She stated that potassium chloride extended-release tablets should not be crushed. She stated that they should be dissolved in water. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated that it was a medication error to administer the medication crushed. She stated that the medication record usually will not let them document the medication administration for medications with parameters unless they added the parameters at the time they administered it. She stated she was not sure how the requirements for blood pressure and pulse were added to the medication administration records. She stated that if staff did not check the blood pressure and pulse prior to administering a medication with parameters, their blood pressure could be too low or too high, and the nursing staff would not know. In an interview with the DON on 12/3/2025 at 10:51AM, she stated that the medication administration record for Resident #28 should have an area where staff were required to document the blood pressure and pulse before giving the hydrocholorothiazide. She stated that she would fix it right away. She stated that the last blood pressure documented for Resident #28 was on 11/14/2025. She stated that staff should check the order prior to administering the medication and notify her if there was not a place to document the blood pressure and pulse. She stated that even without the prompt from the medication administration record, the nurses and CMAs should know to document the blood pressure and pulse. She stated that if the blood pressure and pulse were not charted, she would have to assume that it was not done. She stated that the impact to the resident was that the staff could lower the blood pressure and would not know. ^In an interview with CMA H on 12/3/2025 at 2:48PM, she stated that she had spoken to the DON about the blood pressure and pulse for Resident #28. She stated that she did not see the parameters on the order. She stated that on all the other residents with blood pressure medications there was a prompt for her to enter the blood pressure and pulse if it was required. She stated that she was not told when she trained, on medications, that Resident #28 needed to have her blood pressure and pulse taken with her morning medications. She stated that she would have done it if she had seen it on the medication order. She stated that she saw the parameters for the medication order after she clicked on the medication summary, but not when she was clicking the administration. She stated it was a mistake. She stated that even without the prompt, she should have checked the order for a medication that affected blood pressure. She stated that the impact to the resident of not checking the blood pressure and pulse before administering a blood pressure medication was that it could lower an already low blood pressure. Record Review of facility policy for Medication Administration dated 4/19/2019 reflected: Medications are administered in a safe and timely manner, and as prescribed.Policy interpretation and Implementation.4. Medications are administered in accordance with prescriber orders, including any required time frame.11. The following information is checked/verified for each resident prior to administering medications:a. Allergies to medications, andb. Vital signs, if necessary.