STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675518	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hilltop on Main	1015 N Main Meridian, TX 76665

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview, and record review, the facility failed to implement a comprehensive care plan that describes the services to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents(Resident #1) reviewed for care plans. The facility failed to revise the nutritional careplan and develop and implement a care plan for severe weight loss of 16.1% and refusal to eat identified in a two month period from admission on 12/05/2023 and last record of weight on 02/05/2024. The facility failed to develop and implement a care plan related to Resident # 1 self isolating, blocking his room door,signs, symptoms of depression, and refusal to see Psych NP on 01/15/2024 which resulted in Resident # 1 to attempt suicide on 03/01/2024. An Immediate Jeopardy (IJ) situation was identified on 03/22/2024 at 3:00 p.m. While the IJ was removed on 03/23/2024 at 07:50 a.m., the facility remained out of compliance at a scope of isolated with no actual harm with the potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice placed residents at risk for accidents, diminished quality of life, and suicide. Findings included: Review of Resident #1's undated face sheet revealed an [AGE] year-old male with an admitted [DATE]. Diagnoses included hypertension(high blood pressure), cardiomyopathy(disease of heart muscle), and hyperlipidemia(high cholesterol). Review of Resident #1's MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated moderate cognitive impairment. MDS indicated no behaviors and malnutrition(protein or calorie) or at risk for malnutrition for Resident #1. Review of Resident #1's care plan undated revealed no record of observed behavior that was listed in Resident #1's progress notes dated 02/22/2024. (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: 675518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2024
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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident # 1's care plan undated revealed no record of weight taken once a month every day shift starting on the 1st and ending on the 5th of every month and Health Shakes offered two times a day with lunch and supper meal. Review of Resident #1's physician orders revealed the following: * dated 12/30/2023 to start 01/01/2024 Weigh once a month every day shift starting on the 1st and ending on the 5th every month for weight management. *dated 02/23/2024 to start 02/23/2024 Health Shakes two times a day offer health shake with lunch and supper meal. There was no order to address Resident # 1's behaviors. Review of Resident #1's hospital records dated 03/01/2024 at 11:45 a.m. reflected Resident #1 was presented to the emergency roiagnom on [DATE] for Psychiatric Evaluation (Patient cut wrists) Patient was evaluated in the ER today. He reported not doing well. He stated he is still angry about the situation with his RP. He noted that he asked his RP for money and she refused to give him any. He then asked her if he can only have $15 and she declined. Patient reported that the incident got him upset. When asked about previous episodes of anger, patient noted that in the past when he got angry, he would just say ok and move on but couldn't this time. Review of Resident#1 hospital records dated 03/01/2024 at 1:40 p.m. reflected SW went into room to speak with patient about inpatient hospitalization in a psychiatric facility. Patient stated that will be good because when I leave here I know how to use a gun.'. Review of Resident #1's progress note dated 02/22/2024 at 7:11 p.m. written by LPN G reflected: Resident had turned his bedside table upside down and put it in front of his door to try and block it closed. When asked why he did that he stated that the guy told him he could do that to keep people out of his room. Nurse explained that he could not do that because it was a safety issue and if staff needed to get in there in case of an emergency they couldn't if he blocked the door. Table was taken out of the room. He then pointed to his TV and stated that the guy came and fixed his TV so that the channel couldn't be changed and that the channel it is on now is designed to brainwash him. Nurse tried to explain that the TV was not brainwashing him, but he was insistent that the TV was brainwashing him. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident # 1's progress note dated 03/01/2024 at 8:30 a.m. written by LVN B reflected CNA called this nurse to resident's room. Noted resident laying on his back on his bed with his back leaning against the wall. Bilateral arms stretched out by his sides. Noted lacerations and blood on bilateral wrist. Broken glass from the picture frame scattered on floor. Moderate amount of blood on the floor. CNA removed any items that could be used to self harm from immediate area. Noted numerous lacerations to bilateral wrist. No active bleeding noted. No other injury noted. BP-139/69 P-95 R-18 Temp-97.8 States I was trying to kill myself I cut my wrist with the glass from the picture frame. Then this Nurse asked the resident why he did this to himself resident made comments I've done some bad things in my life. My RP and I was in a inappropriate relationship for a long time. Before my RP married her husband, she found me and wanted to start the relationship back and we did that's why her husband wants me to die I heard him say he wished I was dead Am I going to jail now? One on One initiated at 7:35-Administrator notified. Administrator to notify resident's. Treatment initiated. Hospice nurse notified. 8:10 call placed to 911 for transfer to ER for evaluation and treatment due to suicide attempt. Resident sitting with this Nurse waiting on EMS. This Nurse asked the resident how long he has thought about hurting himself resident states for about 3-4 hours Nurse asked resident did he call for a Nurse or staff member to talk to prior to cutting himself resident states no. Resident transferred to ER by ambulance. Resident laughing and joking with staff. NP notified of above. During an interview on 03/02/2024 at 11:53 a.m. LVN B stated around 7:30 a.m. on 03/01/2024 CNA C reported to her that she noticed blood on the floor in Resident # 1's room. LVN B stated when she went to the resident's room she observed Resident # 1 was laying on his back in the bed with both his arms stretched out along his side. LVN B observed numerous lacerations to both wrists with blood on the floor. LVN B stated she assessed the resident and did not observe active bleeding or any other injuries. LVN B stated a broken picture frame glass was observed to be scattered on the floor. LVN B stated the resident told her he cut his wrist with the glass from the picture frame and he tried to kill himself. LVN B stated she asked the resident why he cut himself and he stated to her that he had done bad things in his life. LVN B stated Resident # 1 stated to her that he and his RP had an inappropriate relationship for a very long time. He expressed to LVN B before his RP married her husband she wanted to start the relationship back and that's why the RP husband wanted him to die. LVN B stated that Resident # 1 stated he had heard his RP husband say he wished he was dead. LVN B stated she had asked Resident #1 how long he had thought of hurting himself and he stated about three to four hours. In an attempted interview on 03/22/2024 at 2:05 p.m. with the DON was unsuccessful by phone call. In an interview on 03/22/2024 at 2:19 p.m. with the ADM stated she expected care plans to be updated when a resident had a change in condition, medication change, or significant event. ADM stated the current MDS nurse worked off-site and did not come to the facility. The ADM stated the MDS nurse did not know the residents and she had requested corporate to get the facility an MDS nurse onsite so when they had incidents and changes in condition the updates could be made at that time. The ADM stated the DON had educated Resident # 1 but did not document the education, or care plan to reflect the interventions. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 03/22/2024 (time not documented) the MDS nurse stated that Resident #1 was on hospice and weight loss was expected. The MDS nurse stated nutrition was care planned for health snacks, and super cereal twice a day if Resident # 1 did not eat over 50% of the meal. The MDS nurse stated the facility still tried to put interventions in place even though the weight loss was expected. The MDS nurse was not able to give elaboration on revisions and dates made to Resident #1's care plan. A record review of the care plans, comprehensive person-centered policy statement revised December 2016 reflected that A comprehensive, person-centered care plan that includes measurable objects and timetables to meet the residents physical, psychosocial, and functional needs is developed and implemented for each resident. A record review of care plans, goals, and objectives revised in 2009(month not dated) reflected that care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. This was determined to be an Immediate Jeopardy (IJ) on 03/22/2024 at 3:00 p.m. The ADM was notified. The ADM was provided with the IJ template on 03/22/2024 at 3:00 p.m. The following Plan of Removal submitted by the facility was accepted on 03/23/2024 at 07:50 a.m. and included: Plan of Removal F656 Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on March 22nd, 2024, for facility failing to initiate, develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs. 1. Action: To ensure the development and implementation of a comprehensive person-centered care plan, the MDS and DON conducted audits and developed care plans on all center residents. If a significant change in the resident condition and treatment is noted during the widespread audit, a change of care plan will be initiated by the MDS nurse and DON to meet individual residents' needs. Completion Timeline: Beginning March 22nd, 2024, and ending March 23rd, 2024. Responsible: DON/MDS Nurse 2. Action: DON and MDS nurse were in-service by the [NAME] President of Clinical Services on March 22nd, 2024, regarding: 1) the development and implementation of comprehensive person-centered care plan upon identification of a resident change in condition to include behaviors, weight loss noted during monthly weight monitoring; and 2) Baseline care plan must be initiated upon admission. Completion Timeline: Beginning March 22nd, 2024, and thereafter. Responsible: [NAME] President of Clinical Services (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Action: Beginning on March 22nd,2024 and for the next 30 days the Director of Nursing will utilize the Daily Clinical Meeting Process and 24 hours report to identify a change in resident conditions including behaviors, weight loss, and new medication orders. DON and MDS nurses will update the resident care plan during the daily clinical meetings. QAPI Committee will be notified of identified non-compliance. QAPI Committee will develop a Performance Improvement Plan to address identified non-compliance to include staff education and/or disciplinary action. Completion Timeline: Beginning March 22nd, 2024, and thereafter. Responsible: DON Monitoring of the plan of removal was completed on 03/24/2024 and revealed the following: In an interview on 03/23/2024 at 3:50 p.m. the ADM stated updating the care plans was the responsibility of the MDS nurse and the DON. The ADM stated that the care plan should be updated the same or within 24 hours after a care conference with the interdisciplinary team. The ADM stated after any identified incidents in-service with staff would be conducted to ensure care plans are being followed. The ADM stated that she and the DON will do rounds to check that residents have care plan interventions in place. A record review of Resident #1's care plan revised dated 03/24/2024 revealed The resident will maintain adequate nutritional status as evidenced by maintaining weight within 3% range through review date with Interventions Identified as: - Diet consult as needed - Observe likes and dislikes when serving diet - Serve supplements if less than 50% of meal intake - Record and report to MD s/s of skin breakdown - Assess oral status, and proper fit of dentures if applicable - ST referral as indicated - Record and report s/s of dehydration to MD - Document % of meal intake in the clinical record. Risk for harm problem: Self-Directed or Other-Directed Behavior Potentially Causing Harm (Episodic) 3/1/24 - resident cut wrist and stated it was a suicide attempt. With a goal of resident will not harm self or others last revised on 03/22/24. A record review of Resident #1's undated care plan revealed intervention of 1to 1 with resident until able to discharge from the hosptial for risk for harm problem. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the care plan audit of the Resident's care plan revisions was completed on 03/24/2024. A total of 18 residents' care plans were audited A record review of Inservice completed on the care plans was completed by the DON and MDS on 03/22/2024. The DON and MDS were trained to ensure that care plans are developed and updated upon a significant change in the resident's condition. DON and MDS were also trained on base line care plans must be initiated upon admission. The ADM was informed the Immediate Jeopardy was removed on 03/26/2024 at 4:360 p.m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review the facility failed to ensure residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that was not possible or the resident preferences indicated otherwise for 1 of 4 residents (Resident #1) reviewed for nutrition status maintenance. The facility failed to ensure Resident # 1 did not sustain a severe weight loss of 16.1% in a two month period from admission on 12/05/2023 and last record of weight on 02/05/2024 The facility failed to follow MD order to take monthly weights beginning on 01/01/2024 for a weight to be taken the 1st through the 5th of each month. The facility failed to include 01/16/2024 weight of 134.6 in Resident # 1's weight log. The facility failed to identify there was a decrease from health shakes being administered three times per day decreasing down to two times a day. An Immediate Jeopardy (IJ) was identified on 03/04/2024 The IJ template was provided to the facility on [DATE] at 10:14 p.m. While the IJ was removed on 03/06/2024 at 4:00 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm. This failure could place residents at risk of weight loss, weight gain, nutritional deficit, and adverse health consequences. Findings included: Review of Resident #1's undated face sheet revealed an [AGE] year-old male with an admitted [DATE]. Diagnoses included hypertension (high blood pressure), cardiomyopathy (disease of heart muscle), hyperlipidemia (high cholesterol), and protein-calorie malnutrition (inadequate amount of protein). Review of Resident #1's physician order dated 12/30/2023 to start 01/01/2024 reflected: Weigh once a month every day shift starting on the 1st and ending on the 5th every month for weight management. Order dated 02/23/2024 to start 02/23/2024 Health Shakes two times a day offer health shake with lunch and supper meal. Review of Resident #1's MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated moderate cognitive impairment. Review of Resident #1's care plan undated revealed resident has a nutritional problem and appetite stimulant ordered. On NAS diet. [DATE] wt 153.1 lbs. Resident # 1 care plan did not include his updated weights or refusal to eat. Resident # 1's care plan did not include signs, symptoms of depression, and refusal to see Psych NP. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress notes dated 12/05/2023 to 03/01/2024 revealed medication refused. 12/23/2023 01/12/2024 01/13/2024 01/14/2024 01/15/2024 01/17/2024 01/18/2024 01/19/2024 01/20/2024 01/21/2024 01/22/2024 01/23/2024 01/24/2024 01/25/2024 01/26/2024 01/27/2024 01/28/2024 01/29/2024 01/30/2024 02/03/2024 02/05/2024 02/06/2024 02/07/2024 (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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	02/08/2024 02/09/2024 02/10/2024 02/11/2024 02/12/2024 02/14/2024 02/15/2024 02/16/2024 02/17/2024 02/19/2024 01/31/2024 Review of Resident #1's progress notes dated 12/05/2023 to 03/01/2024 revealed meals refused. 01/13/2024 01/15/2024 01/16/2024 01/20/2024 01/21/2024 01/24/2024 Review of Resident #1's progress note dated 01/13/2024 at 7:11 p.m. written by LVN B reflected that Resident refusing to eat, drink, and take his medication. Told this nurse that he was tired of taking medicine and said he didn't feel like eating. Offered different meal options to entice him to eat. Will call his RP to discuss, also letting NP know of his change in condition. Review of Resident #1's progress note dated 01/15/2024 at 1:30 p.m. written by CMA D reflected that Resident continues to only take a few bites of meals and is refusing medications. RP aware. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress note dated 01/16/2024 at 10:29 a.m. written by LVN B reflected that Resident refused regular breakfast this AM. Ate 1/2 of a blueberry muffin. Resident weight 134.6. 18.5 lbs weight loss noted from 12/5/2023. Call placed to NP, informed of weight loss and change of condition. New orders received to start Remeron 7.5mg for appetite stimulant. MAR updated. Pharmacy faxed notified. Resident aware and agrees to new orders. Consent signed. Fluids encouraged. Able to make needs known. Call light in reach. Review of Resident #1's progress note dated 01/20/2024 at 2:11 p.m. written by LVN B reflected that Resident taken to dining room for both meals today. Only a couple of bites taken from each meal. Resident continues to refuse medications. This nurse spoke with DON, resident, and resident's regarding resident refusing meals and medication and weight loss. Review of Resident #1's progress note dated 01/21/2024 at 2:23 p.m. written by LVN B reflected that Resident resting in bed. Refused meals and medications after numerous attempts made by this Nurse'. Review of Resident # 1's vitals for weights summary only showed weights for admission 12/05/2023 (wheelchair) 153.1 lbs. 01/17/2024 (standing) 153.1 lbs 02/05/2024 (standing) 128.4 lbs. -10% change comparison weight 12/05/2023 153.1 lbs, -16.1%,-24.7(lbs) -5.0% change comparison weight 01/17/2024,153.1 lbs,-16.1%-24. 7(lbs)-7.5% change comparison weight 12/05/2023, 153.1 lbs, -16.1%-24.7 lbs.'. Resident # 1 had significant weight loss from admission on 12/05/2024 and the last record of weight on 02/05/2024. Review of Resident # 1's MAR reflected health shakes on MAR twice. Once as three times per day until 02/23/2024 after the 8:00 a.m. administration , then decreased to twice per day with lunch and supper on 02/23/2024. During an interview on 03/04/2024 at 1:30 p.m. CNA C stated Resident # 1 on some days would lay in bed and refuse to eat. Resident #1 would eat a little bit of his breakfast but not lunch or dinner. CNA C stated she reported to LVN B when the resident would refuse to eat. CNA C stated the resident did not drink and refused the health shakes. CNA C stated the resident did not like the texture of the health shakes. CNA C stated she was not aware if any substitution was given. During an attempt on 03/04/2024 at 1:55 p.m. unsuccessful attempt in reaching the Medical Doctor. During an interview on 03/04/2024 at 5:30 p.m. CNA D stated that she reported to LVN B when the resident would refuse to eat. CNA D stated the resident had lost a lot of weight due to not eating. Resident # 1 would decline the health shakes because he did not like them. During an interview on 03/04/2024 at 6:15 p.m. the Dietician stated a nutritional assessment was conducted on 02/12/2024 that showed Resident # 1 had experienced weight loss. The dietician stated weekly weights were to be conducted and nursing staff was responsible for weights. Resident # 1 was added a nutritional protein milkshake to aid in helping gain weight. (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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/04/2024 at 6:57 p.m. the DON stated she started as the DON on 03/01/2024. The DON stated weights for normal residents are done once a month by the nurse but if there is a resident who is not eating, losing, or gaining weight they are placed on weekly weights. The DON stated if weight loss is not monitored it would not identify the weight loss. The DON stated not receiving proper nutrients may cause further illness and complications. The DON stated that she, the Dietician, and the Dietary Manager meet to discuss weight and during that time the Dietician writes up the nutrition assessment and recommendations for that particular resident. During an interview on 03/04/2024 at 8:10 p.m. the Dietary Manager stated the DON, the Dietician, and the Dietary Manager discuss weight/loss. The Dietician would write the nutrition assessments. The Dietary Manager stated she talks with residents about their food types/ recommendations followed by The Dietician's orders. The Dietary Manager stated Resident # 1 some days would only eat a few bites of his food. The Dietary Manager stated that she did not document when the resident did not eat. The Dietary Manager stated the DON was responsible for documenting progress notes when residents was not eating. The Dietary Manager stated the Nursing staff was responsible for taking weekly weights when it was determined significant/severe weight loss. The Dietary Manager stated if weights are not conducted weekly it may cause further weight loss that would be too hard on the resident to be weak without protein or nutrients which may cause further illness. During an interview on 03/04/2024 at 8:30 p.m. the ADM stated the nursing staff are responsible for weights and she was unable to give an answer to why Resident#1 weights was not taken. The ADM stated that she would have to take a look into why Resident # 1's weight was not checked weekly with having weight loss. The ADM stated that when residents are not receiving weekly weight checks would cause a slower process in healing and further complications The ADM stated the DON the Dietitian, and the Dietary Manager are responsible for discussing weights for nutritional needs. Review of the facility's policy titled Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol revised 09/2017 reflected: The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time. This was determined to be an Immediate Jeopardy (IJ) on 03/04/2024 at 10:14 p.m. The ADM and DON were notified. The ADM was provided with the IJ template on 03/04/2024 at 10:14 p.m. The following Plan of Removal submitted by the facility was accepted on 03/06/2024 at 10:05 a.m. Plan of Removal F692 Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on March 4th, 2024, for facility failing to initiate timely intervention to prevent significant weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2024
NAME OF PROVIDER OR SUPPLIER The Hilltop on Main		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 N Main Meridian, TX 76665	

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Action: To ensure identification of weight loss, the facility licensed nursing staff conducted/weigh and documented all weight of all center residents. If a change in weight is noted during the widespread audit, the attending physician and Registered Dietitian will be notified to obtain treatment orders as indicated and a change of care plan will be initiated. Weight loss and potential risk factors will be documented in the progress noted and care planned to meet individual residents' needs. Completion Timeline: Beginning March 4th, 2024, and ending March 5th, 2024. Responsible: Licensed Nurses/ Activity Director/DON/MDS 2. Action: DON was in-service by the [NAME] President of Clinical Services on March 4th, 2024, regarding: 1) Notification to attending physician, Registered Dietitian, and responsible representative upon identification of resident change in condition to include weight loss noted during monthly, weekly weight monitoring; and 2) Inspection and documentation of resident weight upon admission, monthly, and weekly thereafter. Beginning March 4th, 2024, Nursing Administration to conduct education with licensed nursing staff on the above education. PRN and New hires who have not received the above stated education will be educated by DON prior to providing resident direct care. Completion Timeline: Beginning March 4th, 2024, and thereafter. Responsible: Director of Nursing 3. Action: Director of Nursing was in-service by the [NAME] President of Clinical Services on March 4th, 2024, regarding certified nursing assistants notifying charge nurse upon identification of change in resident appetite and refusal of a meal. Beginning March 4th, 2024, Nursing Administration to conduct the above education with certified nursing assistants. New hires and PRN who have not received the above stated education will be educated by the DON prior to providing resident direct care. Completion Timeline: Beginning March 4th, 2024, and thereafter. Responsible: Director of Nursing. 4. Actions: The Director of Nursing, Registered Dietitian, and Dietary Manager will meet weekly to discuss resident weight. Each month, the nursing staff will weigh all residents. DON, RD, and DM will compare current weight to previous weight. Based on the report, the IDT will identify weight loss and decide on resident that will receive weekly and daily weight. Registered Dietitian recommendation will be entered and documented into the electronic medical record system by DON. The provider and family representative will be notified of resident weight change and dietary recommendation. Completion Timeline: Beginning March 4th, 2024, and thereafter. Responsible: Administrator and [NAME] President of Clinical Services 5. Action: The Nursing Administration began auditing the electronic medical record of each resident to ensure monthly, weekly, and daily weight are scheduled to be performed by the nursing staff. The DON will ensure that the nursing staff document the resident weight on the EMR. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Completion Timeline: Beginning March 4th, 2024, and thereafter. Responsible: Director of Nursing 6. Action: Beginning on March 4th, 2024. and for the next 30 days the Director of Nursing will utilize the Daily Clinical Meeting Process and the weight report to validate charge nurse compliance with inspection, notification, and documentation of resident weight checks which are to be conducted upon admission, monthly, weekly, and daily thereafter. QAPI Committee will be notified of identified non-compliance. QAPI Committee will develop a Performance Improvement Plan to address identified non-compliance to include staff education and/or disciplinary action. Completion Timeline: Beginning March 4th, 2024, and thereafter. Responsible: Administrator, Director of Nursing Monitoring of the plan of removal was completed on 03/06/2024 and revealed the following: During an interview on 03/06/2024 at 12:00 p.m. RN A stated that he has been in-serviced on reporting weight loss. RN A stated that the Nurses are responsible for weights and to ensure they were recorded accurately. RN A stated the Nurses must report any weight loss observed. RN A stated that the provider, physician, and the Registered Dietitian will be notified of the resident weight loss. During an observation on 03/06/2024 at 12:20 p.m. residents was in the dining room eating lunch. None of the residents refused lunch or appeared to have a lack of an appetite. During an interview on 03/06/2024 at 1:00 p.m. LVN B stated that he had been in-serviced on reporting weight loss. LVN B stated that the Nurse is responsible for recording weight loss. LVN B stated the nurse must report any weight loss and if there is a 4-5-pound weight loss it should be reported immediately. LVN B stated that the RP, physician, and the Registered Dietitian would be notified of the resident weight loss. During an interview on 03/06/2024 at 1:30 p.m. CNA C stated if the CNA's noticed a resident not eating or having a change in appetite they are to report the change in behavior to the Charge Nurse so they can document it. CNA's can document a lack of appetite on the resident's ADL charting. During an interview on 03/06/2024 at 2:00 p.m. the Activity Director stated if the CNA's noticed a change in appetite or a resident refusing to eat they are supposed to notify the Charge Nurse immediately. The Activity Director stated if the CNAs noticed a resident was losing weight, they was supposed to notify the Charge Nurse immediately. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/06/2024 at 3:00 p.m. the DON stated she has been in-serviced by the [NAME] President of Clinical Services on the following: CNAs must notify the Charge Nurse about changes in resident appetite and refusing to eat. The DON stated CNA's would notify a Charge Nurse if a resident doesn't eat or even if they only eat half of their meal. The DON stated a nurse would be responsible for documenting the change in condition. The DON and interdisciplinary team will address change in condition, DON, RD, and DM must meet weekly to discuss residents' weights, weekly weights, and look at weight trends. The DON stated she would be responsible for auditing the electronic medical records to ensure residents were weighed. DON stated she trained the RNs, LVNs, and CNAs on resident's weights. Review of the Inservice completed on 3/04/2024 for Charge Nurses provided by the DON. Charge Nurses Inservice- responsible to ensure weights are completed and report weight loss to the provider. Review of the Inservice completed on 3/04/2024 for CNA's and CMA's provided by the DON. CNA's CMA's Inservice-reporting change in appetite and refusals of meals to the Charge Nurse. The DON was informed the Immediate Jeopardy was removed on 03/06/2024 at 4:00 p.m. The facility remained out of compliance at a scope of iolated severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interviews and record reviews the facility failed to ensure a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment disorder receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for 1 of 4 residents (Resident # 1) reviewed for treatment and services for mental and psychosocial concerns. The facility failed to develop and implement a plan of care to address Resident #1's signs and symptoms first documented on 01/15/2024 when Resident #1 refused to see the Psych NP for signs and symptoms of depression. CMA D failed to to report Resident #1 expressing to her many times that he was tired, his body was giving out, and he was ready to go. The facility failed to act upon ,care plan develop, and implement Resident # 1's changes noted by CNA C, CMA D reported to LVN B and CNA E reported to the former DON. An Immediate Jeopardy (IJ) was was identified on 03/04/2024 The IJ template was provided to the facility on [DATE] at 10:14 p.m. While the immediacy was removed on 03/06/2024 at 4:00 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm. This deficient practice placed residents at risk for prolonged pain, suffering, injury, hospitalization , and death. Findings included: Review of Resident #1's undated face sheet revealed an [AGE] year-old male with an admitted [DATE]. Diagnoses included hypertension (high blood pressure), cardiomyopathy (disease of heart muscle), and hyperlipidemia (high cholesterol). Review of Resident #1's physician order dated 12/05/2023 reflected: Psychiatric evaluation and treatment as indicated. Review of Resident #1's MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated moderate cognitive impairment. Review of Resident #1's care plan undated revealed no record of observed behavior that was listed in Resident #1's progress notes dated 02/22/2024. No record of plan to address changes in condition for Resident #1. Resident #1's care plan did not address the changes noted by CNA C, CMA D, and CNA E reported to LVN B and the previous DON. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress notes dated 12/05/2023 to 03/01/2024 there was no documentation of education,encouragement, additional attempt/encouragement to obtain/ provide treatment documented regarding psych services. Review of Resident #1's progress notes dated 12/05/2023 to 03/01/2024 revealed medication refused. 12/23/2023 01/12/2024 01/13/2024 01/14/2024 01/15/2024 01/17/2024 01/18/2024 01/19/2024 01/20/2024 01/21/2024 01/22/2024 01/23/2024 01/24/2024 01/25/2024 01/26/2024 01/27/2024 01/28/2024 01/29/2024 01/30/2024 02/03/2024 02/05/2024 (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident # 1's progress note dated 01/15/2024 at 1:30 p.m. written by LVN B reflected: Resident continues to only take a few bites of meals and is refusing medications. RP aware. This Nurse spoke with the resident in length. Resident states I've never lived in trash like this. Resident has been in a different room d/T Covid. Resident states I want to go back to my room. Resident and belongings moved back to room [ROOM NUMBER]-A. Administrator aware. Residents daughter notified and thanked this Nurse. Resident did eat 1/2 bowl of soup for lunch. Vitals stable. Lone Star Psych NP here at the time. This Nurse spoke with the resident about seeing Psych Services for s/s of depression. Resident states not right now I think I'm going to be feeling better now. Resident refused Psych services at this time. This Nurse encouraged resident to eat meals and take his medication as ordered. Informed resident that he can ask for alt food if he does not like/want what is on the menu. Resident verbalized understanding. Able to make needs known. Call light in reach. Review of Resident # 1's progress note dated 01/16/2024 at 4:25 p.m. written by PREV DON reflected: Spoke with resident about his medications. He thinks he is taking too many. I explained most of them he came from the hospital with. I sent a message to the NP to see if we can d/c anything. Awaiting response at this time. Review of Resident #1's progress note dated 02/22/2024 at 7:11 p.m. written by LPN G reflected: Resident had turned his bedside table upside down and put it in front of his door to try and block it closed. When asked why he did that he stated that the guy told him he could do that to keep people out of his room. Nurse explained that he could not do that because it was a safety issue and if staff needed to get in there in case of an emergency they couldn't if he blocked the door. Table was taken out of the room. He then pointed to his TV and stated that the guy came and fixed his TV so that the channel couldn't be changed and that the channel it is on now is designed to brainwash him. Nurse tried to explain that the TV was not brainwashing him but he was insistent that the TV was brainwashing him. Review of Resident # 1's progress note dated 03/01/2024 at 8:30 a.m. written by LVN B reflected CNA called this nurse to resident's room. Noted resident laying on his back on his bed with his back leaning against the wall. Bilateral arms stretched out by his sides. Noted lacerations and blood on bilateral wrist. Broken glass from the picture frame scattered on floor. Moderate amount of blood on the floor. CNA removed any items that could be used to self harm from immediate area. Noted numerous lacerations to bilateral wrist. No active bleeding noted. No other injury noted. BP-139/69 P-95 R-18 Temp-97.8 States I was trying to kill myself I cut my wrist with the glass from the picture frame. Then this Nurse asked the resident why he did this to himself resident made comments I've done some bad things in my life. My RP and I was in a inappropriate relationship for a long time. Before my RP married her husband, she found me and wanted to start the relationship back and we did that's why her husband wants me to die I heard him say he wished I was dead Am I going to jail now? One on One initiated at 7:35-Administrator notified. Administrator to notify resident's. Treatment initiated. Hospice nurse notified. 8:10 call placed to 911 for transfer to ER for evaluation and treatment due to suicide attempt. Resident sitting with this Nurse waiting on EMS. This Nurse asked the resident how long he has thought about hurting himself resident states for about 3-4 hours Nurse asked resident did he call for a Nurse or staff member to talk to prior to cutting himself resident states no. Resident transferred to ER by ambulance. Resident laughing and joking with staff. NP notified of above. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's hospital records dated 03/01/2024 at 11:45 a.m. reflected Resident #1 was presented to the emergency roiagnom on [DATE] for Psychiatric Evaluation (Patient cut wrists) Patient was evaluated in the ER today. He reported not doing well. He stated he is still angry about the situation with his RP. He noted that he asked his RP for money and she refused to give him any. He then asked her if he can only have $15 and she declined. Patient reported that the incident got him upset. When asked about previous episodes of anger, patient noted that in the past when he got angry, he would just say ok and move on but couldn't this time. Review of Resident#1 hospital records dated 03/01/2024 at 1:40 p.m. reflected SW went into room to speak with patient about inpatient hospitalization in a psychiatric facility. Patient stated that will be good because when I leave here I know how to use a gun.'. During an interview on 03/02/2024 at 11:53 a.m. LVN B stated around 7:30 a.m. on 03/01/2024 CNA C reported to her that she noticed blood on the floor in Resident # 1's room. LVN B stated when she went to the resident's room she observed Resident # 1 was laying on his back in the bed with both his arms stretched out along his side. LVN B observed numerous lacerations to both wrists with blood on the floor. LVN B stated she assessed the resident and did not observe active bleeding or any other injuries. LVN B stated a broken picture frame glass was observed to be scattered on the floor. LVN B stated the resident told her he cut his wrist with the glass from the picture frame and he tried to kill himself. LVN B stated she asked the resident why he cut himself and he stated to her that he had done bad things in his life. LVN B stated Resident # 1 stated to her that he and his RP had an inappropriate relationship for a very long time. He expressed to LVN B before his RP married her husband she wanted to start the relationship back and that's why the RP husband wanted him to die. LVN B stated that Resident # 1 stated he had heard his RP husband say he wished he was dead. LVN B stated she had asked Resident #1 how long he had thought of hurting himself and he stated about three to four hours. During an interview on 03/02/2024 at 1:17 p.m. CMA D stated Resident # 1 expressed to her often that he was tired, his body was giving out, and he was ready to go. (as in death). CMA D stated she did not make a report to anyone as she did not think Resident # 1 would harm himself. CMA D stated it was many times Resident # 1 would not eat and refuse his medication. During an interview on 03/02/2024 at 1:47 p.m. CNA C stated on 03/01/2024 around 7:30 a.m. she was passing Resident # 1's breakfast tray and upon entering the resident's room she observed Resident # 1 with both arms covered in blood. CNA C stated there was blood on the floor in front of the bed, along with a family picture frame broken. CNA C stated that she observed broken glass that was scattered on the floor. CNA C stated that she asked Resident #t what had happened and he only stated he just messed up. During an interview on 03/02/2024 at 3:00 p.m. the ADM stated LVN B notified her by phone around 8:00 a. m. on 03/01/2024 that Resident # 1 had harmed himself. The ADM stated she asked Resident #1 as he was leaving with EMS what had happened and his response was he had tried to kill himself. The ADM stated the incident with the bedside table at the front door Resident # 1 was only trying to prevent staff from coming into his room and interrupting his sleep. The ADM stated this is what Resident # 1 stated to her. During an attempted interview on 03/04/2024 at 1:55 p.m. was unsuccessful reaching the Medical Doctor. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/04/2024 at 5:00 p.m. CNA C stated Resident # 1 did have days that he would just lay in bed and not want to eat his food. CNA C stated she reported to LVN B that the resident would just lie in bed and refuse to eat. CNA C stated she could not recall the number of times or the dates Resident # 1 would lie in bed and refuse meals. During an interview on 03/04/2024 at 5:30 p.m. CMA D stated that she would report to LVN B when she observed Resident # 1 was not eating meals or refusing his medications. During an interview on 03/04/2024 at 5:45 p.m. CNA E stated she sat with Resident # 1 until the ambulance arrived to transport him to the hospital. CNA E stated she asked Resident # 1 what had happened and he said he just thought about leaving (as in death). Resident # 1 did not elaborate or discuss any further. CNA E stated she would report changes in conditions to the previous DON (no longer with the facility) when Resident # 1 would just lie around and refuse his meals During an interview on 03/04/2024 at 8:30 p.m. the ADM stated changes in conditions when identified will need to be reported to the Charge Nurse and they are responsible for the documentation. Review of the facility's policy titled BEHAVIOR HEALTH SERVICES revised 02/2019 reflected: Policy Statement The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. This was determined to be an Immediate Jeopardy (IJ) on 03/04/2024 at 10:14 p.m. The ADM and DON were notified. The ADM was provided with the IJ template on 03/04/2024 at 10:14 p.m. The following Plan of Removal submitted by the facility was accepted on 03/06/2024 at 10:05 a.m.: Plan of Removal F742 Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on March 4th, 2024, for facility failing to initiate timely intervention to treat psychosocial concerns. 1. Action: To ensure identification of psychosocial concerns, the facility licensed nurses/social service staff conducted and documented psychosocial concerns such as depression and suicide thoughts on all center residents. If a change in the resident behavior and mood is noted during the widespread audit, the attending physician will be notified to obtain treatment orders as indicated and a change of care plan will be initiated. The Director of Nursing and charge nurse will refer the resident for psychological services and potential risk factors will be documented in the progress note and care planned to meet individual residents' needs. Completion Timeline: Beginning March 4th, 2024, and end March 5, 2024. Responsible: Licensed Nurses/ Activity Director/DON/MDS (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Action: Director of Nursing was in-service by the [NAME] President of Clinical Services on March 4th, 2024, regarding: 1) Notification to attending physician and family representative upon identification of resident change in condition to include mental and psychosocial behavior noted during auditing/monitoring and 2) Inspection and documentation of resident behavior upon admission, monthly, and weekly thereafter. Beginning March 4th, 2024, Nursing Administration to conduct the above education to licensed nurses. PRN and new hires who have not received the above stated education will be educated by the DON prior to providing resident direct care. Completion Timeline: Beginning March 4th, 2024, and thereafter. Responsible: Director of Nursing 3. Action: Director of Nursing was in-service by the [NAME] President of Clinical Services on March 4th, 2024, regarding certified nursing assistant notifying the charge nurse upon identification of change in resident condition such as behavior and mood. Beginning March 4th, 2024, Nursing Administration to conduct the above education with certified nursing assistants. New hires and PRN who have not received the above stated education will be educated by the DON prior to providing resident direct care. Completion Timeline: Beginning March 4th, 2024, and thereafter. Responsible: Director of Nursing 4. Actions: The Director of Nursing and the interdisciplinary team will meet 5 days a week to discuss resident change in condition including mental and psychosocial concerns. The DON will ensure that the provider is made aware of the patient's change in condition, referral order for psychological services and treatment plan is entered and documented into the electronic medical record system. The family representative will be notified of the resident change in condition and treatment plan. Completion Timeline: Beginning March 5, 2024, and thereafter. Responsible: Administrator and [NAME] President of Clinical Service. 5. Action: The Nursing Administration began auditing the electronic medical record of each resident to ensure treatment plans are scheduled to be performed by the nursing staff. The DON will ensure that the nursing staff are monitoring and documenting the resident's change of condition such as behavior on the progress note. Completion Timeline: Beginning March 4th, 2024, and thereafter. Responsible: Director of Nursing 6. Action: Beginning on March 4th, 2024. and for the next 30 days. The Director of Nursing will utilize the 24 hours report to validate charge nurse compliance with inspection, notification, and documentation of resident change in behavior and mood are conducted upon admission and daily thereafter. QAPI Committee will be notified of identified non-compliance. QAPI Committee will develop a Performance Improvement Plan to address identified non-compliance to include staff education and/or disciplinary action. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2024
NAME OF PROVIDER OR SUPPLIER The Hilltop on Main		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 N Main Meridian, TX 76665	

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Completion Timeline: Beginning March 4th, 2024, and thereafter. Responsible: Administrator, Director of Nursing Monitoring of the plan of removal was completed on 03/06/2024 and revealed the following: During an interview on 03/06/2024 at 12:00 p.m. RN A stated that he was on monitor for residents that may have psychosocial concerns. RN A stated if a resident is not acting their normal self such as crying, sad, or depressed those were signs of change in behavior. RN A stated a change in behavior, change in appetite, or lack of eating also should be reported to nursing staff if witnessed. RN A stated the DON, Physician, and Charge nurse should be notified of the resident's changes. RN A stated it is important to report and document the changes in behavior so the resident can get the appropriate help they may need. RN A stated the change of condition should be followed up on for 72 hrs. During an interview on 03/06/2024 at 1:00 p.m. LVN B stated that she was on monitor for residents that may have psychosocial concerns. LVN B stated changes of behavior signs are depressed, crying, or sad. LVN B stated the change in behavior signs should be documented and reported. LVN B stated the DON, Physician, and Charge nurse should be notified of the resident's changes. LVN stated it was important to report and document the changes in behavior so the residents could get their medical needs met. During an interview on 03/06/2024 at 1:30 p.m. CNA C stated if she noticed a resident with a change in condition she would report the change in behavior to the Charge Nurse. CNA C stated that the Charge Nurse would document the change in behavior if a resident was sleeping more than normal, being agitated, or having aggressive outbursts. During an interview on 03/06/2024 at 2:00 p.m. the Activity Director stated that if a resident stated they don't want to live or acting differently the CNAs should notify the Charge Nurse so that the resident can get the appropriate medical help. The Activity Director stated signs of change of behavior are becoming aggressive, withdrawn, sad, depressed, and not eating. During an interview on 03/06/2024 at 3:00 p.m. the DON stated she had been in-serviced by the [NAME] President of Clinical Services on notifying the Charge Nurse of changes in the conditions of residents. The DON stated the Charge Nurse would be responsible for documenting changes in conditions. Nurses must notify the attending provider of the resident change in condition including mental psychosocial behavior, along with documenting and monitoring. The DON stated CNA's and CMA's must report changes in mood or behavior to the Charge Nurse. The DON stated that she trained the RNs, LVNs, and CNAs on changes in conditions. Review of the Inservice completed on 3/04/2024 for Charge Nurses provided by the DON. Charge Nurses Inservice- monitor resident's behavior's, documenting ,notify attending provider, and psychosocial behavior. Review of the Inservice completed on 3/04/2024 for CNA's and CMA's provided by the DON. CNA's CMA's Inservice-reporting change in conditions and behaviors to the Charge Nurse. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON was informed the Immediate Jeopardy was removed on 03/06/2024 at 4:00 p.m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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** 44671 Based on interview and record review, the facility failed to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 (Resident #1) of 4 residents reviewed for psychotropic drug use. The facility failed to: 1. ensure Resident #1 was prescribed Seroquel for a specific diagnosis and instead prescribed it for behavioral disturbance at bedtime This failure could affect residents by placing them at risk of receiving psychotropic medications which could cause a decrease in quality of life and increase the risk of injury. Findings included: Review of Resident #1's undated face sheet revealed an [AGE] year-old male with an admitted [DATE]. Diagnoses included hypertension (high blood pressure), cardiomyopathy (disease of heart muscle), hyperlipidemia (high cholesterol), and protein-calorie malnutrition (inadequate amount of protein). Review of Resident #1's MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated moderate cognitive impairment. It further revealed he usually understood others. It revealed that he had no hallucinations nor did he have delusions that would be potential indicators of psychotic behaviors. Review of Resident #1's progress note revealed a note by LPN G on 02/22/2024 at 7:11 p.m. reflected: Resident had turned his overbed table upside down and put it in front of his door to try and block it closed. When asked why he did that he stated that the guy told him he could do that to keep people out of his room. Nurse explained that he could not do that because it was a safety issue and if staff needed to get in there in case of an emergency they couldn't if he blocked the door. Table was taken out of the room. He then pointed to his tv and stated that the guy came and fixed his tv so that the channel couldn't be changed and that the channel it is on now is designed to brainwash him. Nurse tried to explain that the tv was not brainwashing him but he was insistent that the tv was brainwashing him. Record review of Resident #1's progress notes revealed a note by RN G on 02/24/2024 at 12:41 a.m. reflected Resident started Seroquel 50mg last night to help with sleep and decrease agitation. Resident appears to be sleeping normally. Record review of Resident #1's progress notes revealed a note by LVN E on 02/24/2024 at 6:56 p.m. reflected Continue Seroquel for sleep and agitation with no adverse reactions noted. No complaints voiced at the time. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes revealed a note by LVN E on 02/25/2024 at 10:17 p.m. reflected Continue Seroquel for sleep and agitation with no adverse reactions noted. No complaints voiced at the time. In an interview on 03/02/2024 at 2:30 p.m. the DON stated Resident # 1 was placed on Seroquel because of the incident on 02/22/24 of Resident # 1 turning the bedside table upside down in front of his room door. The DON stated Resident # 1 was not placed on 1 to 1 and it was figured the Seroquel would help. In an interview on 03/02/2024 at 3:00 p.m. with the ADM stated Resident #1 had an incident with placing his bedside table in the front of his door was only to prevent staff from coming in and interrupting his sleep. The ADM could not answer why Seroquel's medication was given without any diagnosis. In an interview on 03/04/2024 at 1:59 p.m. with the Hospice Medical Director stated he was getting telephone calls from the facility that Resident # 1 was having aggressive behaviors toward staff was that was the reason for Resident #1 being placed on Seroquel. In an interview on 03/04/24 at 6:57 p.m. the DON stated the previous DON (no longer employed) should have notified the Hospice Medical Director to advise on the consent for Seroquel it showed a diagnosis of sundowning and that is not a diagnosis. The DON stated Resident #1's RP signed off on the consent for Seroquel and she wanted Resident #1to be on the medication. The DON stated the Hospice Medical Director should have been more specific because Medical Doctors have to make a medical diagnosis of a resident. The DON stated the facility was not able to care plan without a medical diagnosis of Seroquel. The DON stated medication was given as ordered by the Doctor and not by a diagnosis. The DON stated any medication can cause an adverse effect or harm if taken if it hasn't been prescribed for a diagnosis. In an interview on 03/04/2024 at 8:30 p.m. with the ADM stated the previous DON (no longer employed) last day in the building on 02/23/2024 overlooked there was not a diagnosis for the Seroquel. The ADM stated the previous DON (no longer employed) should had confirmed if there was a diagnosis for the Seroquel. The ADM stated diagnoses are made by physicians. The ADM stated the orders made by the physician were followed by the facility. The ADM stated if medical diagnosis had not been confirmed and psychotropic medications were given to the resident it could cause suicidal thoughts. Record review of Resident #1's Order dated 02/23/2024 revealed an order for Seroquel oral tablet 50 mg start date of 02/23/2024. Give 1 tablet by mouth at bedtime for agitation and hallucinations. Record review of Resident #1's MAR, February of 2024, revealed he was administered Seroquel on the following dates: 02/23/2024 02/24/2024 02/25/2024 02/26/2024 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/27/2024 02/28/2024 02/29/2024 Record review of Resident #1's diagnoses list viewed 03/02/2024 revealed no diagnosis of psychosis, schizophrenia, or bipolar disorder. Resident # 1 did not have any mental health diagnoses, no anxiety, no depression, or no insomnia. Review of the facility's policy titled Antipsychotic Medication revised 07/2022 reflected: Residents will not receive medications that are not clinically indicated to treat a specific condition.