STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675667	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing Center	7480 Beechnut Houston, TX 77074

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect of residents and ensure reporting of crimes occurring in federally-funded long-term care facilities for 2 of 11 residents (Residents #24 and #45) reviewed for abuse and neglect. 1. The facility failed to report Resident #24's allegations that on 5/11/24 CNA C touched her groin area without her permission. 2. The facility failed to report Resident #45's allegations that on 5/15/24 someone grabbed her hands and shoved her in bed during the night. This failure could place residents at risk for abuse and/or neglect. Findings included: Record review of the facility's Abuse, Neglect and Exploitation Policy published 10/03/2023 revealed that all Agency employees and contractors are required, and have the legal obligation to, report suspected abuse, neglect, and/or exploitation to the Texas Health and Human Services Department of Aging and Disability Services .If there is cause to believe abuse, neglect, or exploitation of a resident has occurred by a facility employee, representative, volunteer or contractor, the incident(s) will be reported to THHS and DADS as per state and federal regulatory requirement, upon witnessing the act or upon receipt of the allegation. 1. Record review of Resident #24's Face Sheet dated 08/21/24 revealed a [AGE] year-old who was originally admitted on [DATE] due to healing after a fracture of their third lumbar vertebra. Other medical diagnoses included: hypothyroidism (a condition where the thyroid gland does not produce enough hormones to effectively regulate a person's metabolism), Bipolar Disorder (a mental illness characterized by severe high and low moods and changes to sleep, energy, thinking and behavior; also called manic depression), and Lupus Erythematosus (an autoimmune disease that can affect many body systems, causing rashes, inflammation, fatigue and fever). Record review of Resident #24's care plan last reviewed on 5/9/24 revealed the following focus areas: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #24 has a self-care deficit related to inability to perform activities of daily living independently, with interventions including allowing sufficient time for hygiene, encouraging Resident #24 to participate in hygiene and praise accomplishment as able, monitoring skin daily and weekly as needed, provide and observe resident's privacy and rights at all times. -Resident #24 is on Antidepressant medication related to Bipolar Disorder, with interventions including giving antidepressant medications ordered by physician and monitoring and documenting side effects and effectiveness, and monitoring, documenting, and reporting to the physician ongoing symptoms of depression such as being sad, irritable, crying, shame, suicidal ideations, fatigue, fear of being alone or with others, unrealistic fears, attention seeking, and anxiety. Record review of Resident #24's Comprehensive MDS (resident assessment tool) dated 04/29/2024 revealed a BIMS (brief interview measuring cognitive intactness) score of 14, indicating intact cognition. Further review revealed that Resident #24 was totally dependent on helper(s) for toileting hygiene. Record review of Resident #24's progress notes: - 05/11/2024 at 9:03pm, reflected LVN D wrote that she was notified by a CNA that Resident #24 refused care. Resident #24 told LVN D that she was fine and just didn't want anyone touching her crotch without her permission. - 5/12/24 at 8:15am, LVN C wrote that Resident #24 told her that last night she was upset with staff with inappropriate touching of her crotch and that she does not feel safe with the night shift that was on. Resident #24 also told her she felt safe at that time. -5/12/24 at 10:46am, the former DON wrote that the resident refused to be changed because she doesn't want anyone touching her in her peri area (resident referred to it as her crotch) without permission. Resident #24 expressed to the former DON that she was uncomfortable when the sheet was pulled back so she can be checked for incontinence. Record review of Resident #24's transfer form dated 05/12/2024 revealed she was transferred out of the facility for suicidal ideation. Further review revealed Resident #24 had no skin injuries and used a walker at the time of transfer. Record review of TULIP (portal where facilities report incidents to the state) on 08/19/2024 revealed no facility self-reports for Resident #24 or Resident #45's incidents. Observation of the facility on 8/21/2024 at 10:21am, revealed there was a sign posted in the front lobby listing the two Abuse Coordinators' contact information, who were the QS and interim Administrator. Interview with the CM on 8/23/24 at 10:38am, he said that Resident #24 complained about the incident the day after on 5/12/24 but that it was related to the can being too rough during incontinent care and that she preferred a nurse do it rather than a CNA. He denied that Resident #24 implied abuse. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the QS on 8/23/24 at 11:07am, he said that his job responsibilities as Quality Patient Safety Specialist were to review incidents and accidents and reporting processes. He said the facility used an escalation algorithm to determine if an incident is reportable to the State, which included reviewing the allegation, interviewing relevant personnel, huddling with leaders in the Risk and Legal department and deciding from there to report or not. The QS said he did not remember the incident with Resident #24 and said he would have to defer to his notes. Later interview with the QS on 8/23/24 at 12:30pm, he could not find any documentation related to Resident #24's incident. Interview with the interim Administrator on 8/23/24 at 11:10am, interim Administrator said he started working in his current position in July 2024. He said he was not aware of Resident #24's incident. He said any allegations of abuse should be immediately reported to the HHSC. The Administrator said staff are to report any allegations of abuse to their charge nurse and then to the Abuse Coordinator. Interview with the VPO on 08/23/2024 at 11:34am, she said she did not remember Resident #24's incident. The VPO stated she is aware that allegations of abuse should be reported within a two-hour timeframe. Interview with the QD on 8/23/24 at 11:49am, she said if resident reports experiencing abuse, the facility does an internal investigation, and if the incident is determined reportable, that was when it is reported to the state. The QD said she did not remember Resident #24's incident but that based on the allegations the facility would have reported if they knew. Interview with the former DON on 8/23/24 at 3:02pm, she said she started working at the facility on 5/26/24 and never heard about Resident #24's incident. Interview with the former Administrator on 8/23/24 at 3:20pm, the former Administrator said and that they remembered Resident #24's incident. They said the facility decided the incident was not reportable due to Resident #24's diagnoses. She said the former DON, a former nurse, wrote a clarifying statement in Resident #24's nursing progress notes that left out the part of her allegation stating that someone touched her inappropriately. The facility said the resident was delusional and was having a psychotic episode. Attempted interview with CNA C on 08/20/2024 at 12:05pm, left a voicemail. Attempted interview with LVN D on 08/22/24 at 10:58 am, left a voicemail. Attempted interview with LVN C on 08/20/2024 at 12:03pm, left a voicemail. 2.Record review of Resident #45's face sheet dated 08/22/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #45 had diagnoses which included: atrial fibrillation (an irregular heartbeat), hypertension (when the pressure in your blood vessels is too high), gastroenteritis (inflammation of the stomach intestinal lining) and colitis (inflammation in the colon). Record review of Resident #45's admission MDS assessment dated [DATE] revealed a BIMS score of 13 of 15 which indicated intact cognition. Further review revealed the resident needed extensive assistance to total assistance with ADLs which required at least one staff assistance. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #45's care plan initiated on 03/29/24 revealed resident had an ADL self-care deficit related to inability to perform activities of daily living independently. Intervention: Requires assistance of staff. Record review of Resident #45's progress note dated 05/16/24wrote by RNA read in part .DON notified writer that patient has complains during therapy session today and wants writer to f/u. Writer interviewed patient and patient notified writer that someone had grabbed both her hands and shoved her in bed last night. Patient proceeded to show writer some bruises on her arms. She pointed to one bruise and said, this is old, but these ones were from yesterday from where I was grabbed, pointing to 2 different bruises. Patient stated Last night a young lady, came to my room, grabbed both my hands and shoved me in bed. I asked the young lady what you are doing? but she did not say anything. Head-to -toe assessment performed on patient. Patient alert and oriented X2-3 with some forgetfulness . Record review of Resident #45's progress note dated 5/16/24 wrote by RN A read in part . notified RP about incident and RP notified writer that she had called patient on Wednesday (05/15/24) morning around 9-10am, and patient had reported the incident to her that someone grabbed her hands and shoved her in bed during the night. RP said that she was waiting to bring it up during the care plan meeting on Friday. Administrator was notified . During an interview on 08/21/24 at 3:33 p.m., RT B said Resident #45 mentioned to him while she was in therapy that a staff grabbed her hand, and it was during transfer. RT B said he told the former DON and the former Administrator at the time. RT B said Resident #45 told him she was grabbed by the forearms and she had discoloration on her arms but was not sure if it was from the incident or not. RT B said the former DON came and assessed the resident, and she took the resident out of the gym and continued to check on Resident #45. During an interview on 08/23/24 at 10:53 a.m., CM said he did not remember any incident with Resident #45. CM said he would research it and notify the surveyor about his findings. During an interview on 08/23/2024 at 11:13 a.m., QS said he could not recall any incident about Resident #45. QS said he would investigate and get back to the surveyor. During an interview on 08/23/24 at 11:19 a.m., the Administrator said he must report to HHSC immediately and then start the investigation. The Administrator stated that if a staff member were identified in the incident, he would suspend the staff member while continuing the investigation. The Administrator said he would also notify Resident #45 physician and the responsible party. The Administrator said they would conduct quality of life and safety questions and in-service on abuse/neglect for the staff. The Administrator said he was unaware of the incident or allegation of abuse complaint by Resident #45 because he was not in the facility then. During an interview on 08/23/24 at 1134 a.m., VPO said she was not sure about Resident #45's alleged abuse, but she would research it and get back to the surveyor. Then, VPO said she thought there was an incident they did huddle about regarding Resident #45, but she was not sure. (continued on next page)

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University Place Nursing Center	7480 Beechnut Houston, TX 77074

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/23/24 at 11:49 a.m., QD said she recalled she went and talked to Resident #45, and Resident #45 asked her to look at her arm, and she asked her to tell her how it happened. QD said that Resident #45 did not know how it had happened and that it was purple. QD said Resident #45 said if she bumped into anything, she would get bruised. QD said that the discolorations were not really bruises on Resident #45's arms because she was on a blood thinner, and she could bruise easily. QD said she did not interview RN A or RT B During an interview on 08/23/24 at 12:07 p.m., RN A said she was at the nursing station when the former DON came and told her that Resident #45 complained that somebody was rough with her. RN A said Resident #45 told her the incident happened during the night shift when she went and assessed Resident #45. RN A said Resident #45 told her a staff was rough and pulled her hand and pushed her into the bed, and Resident #45 had bruises on her arms. RN A said when she called Resident #45's family member to tell her about Resident #45's allegation of abuse, the family told her Resident #45 had already called and notified her that the staff had been rough with her a day before. RN A said she called the former Administrator and told her about the alleged abuse, and the former Administrator said she would investigate the allegation of abuse. During an interview on 08/23/24 at 12:30 p.m., QS came back and said he could not find any information about Resident #45's abuse allegation. During an interview on 08/23/24 at 12:44 p.m., VPO returned and said she could not find any information on Resident #45's incident. During an interview on 08/23/24 at 2:44 p.m., the former DON said she remembered; RT B told her Resident #45 complained she was grabbed and pushed into the bed. The former DON said Resident #45 told her a young girl about 16 or [AGE] years old pulled her hands a little harder when she was taking her to the restroom. The former DON said she saw Resident #45's hands and would not call it bruises because it was bleeding under the skin and appeared like purpura (when small blood vessels burst, and blood pools under the skin). The former DON said Resident #45 had it all over her arms and legs, but she pointed to some areas and said these happened last night when she pulled her hands. The former DON said when she reported to the VPO, she told her to stop the investigation and that the team would take over the investigation. During an interview on 08/23/24 at 3:22 p.m., the former Administrator said she heard that Resident #45 said somebody went into the room and grabbed her hands, and RN A did not report the alleged abuse to her but to the VPO. The former Administrator said RN A, who assessed Resident # 45, said she called to notify Resident #45's family member, and the family member said Resident #45 notified her early this week. The former Administrator said that as an administrator, whenever a resident alleged any abuse, it should be reported to HHSC, and then you should investigate.

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University Place Nursing Center	7480 Beechnut Houston, TX 77074

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately to the State survey Agency in accordance with State law through established procedures for 2 of 11 residents (Residents #24 and #45) reviewed for abuse and neglect. 1. The facility failed to report Resident #24's allegations that on 5/11/24 CNA C touched her groin area without her permission. 2. The facility failed to report Resident #45's allegations that on 5/15/24 someone grabbed her hands and shoved her in bed during the night. This failure could place residents at risk for abuse and/or neglect. Findings included: 1. Record review of Resident #24's Face Sheet dated 08/21/24 revealed a [AGE] year-old who was originally admitted on [DATE] due to healing after a fracture of their third lumbar vertebra. Other medical diagnoses included: hypothyroidism (a condition where the thyroid gland does not produce enough hormones to effectively regulate a person's metabolism), Bipolar Disorder (a mental illness characterized by severe high and low moods and changes to sleep, energy, thinking and behavior; also called manic depression), and Lupus Erythematosus (an autoimmune disease that can affect many body systems, causing rashes, inflammation, fatigue and fever). Record review of Resident #24's care plan last reviewed on 5/9/24 revealed the following focus areas: -Resident #24 has a self-care deficit related to inability to perform activities of daily living independently, with interventions including allowing sufficient time for hygiene, encouraging Resident #24 to participate in hygiene and praise accomplishment as able, monitoring skin daily and weekly as needed, provide and observe resident's privacy and rights at all times. -Resident #24 is on Antidepressant medication related to Bipolar Disorder, with interventions including giving antidepressant medications ordered by physician and monitoring and documenting side effects and effectiveness, and monitoring, documenting, and reporting to the physician ongoing symptoms of depression such as being sad, irritable, crying, shame, suicidal ideations, fatigue, fear of being alone or with others, unrealistic fears, attention seeking, and anxiety. Record review of Resident #24's Comprehensive MDS (resident assessment tool) dated 04/29/2024 revealed a BIMS (brief interview measuring cognitive intactness) score of 14, indicating intact cognition. Further review revealed that Resident #24 was totally dependent on helper(s) for toileting hygiene. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's progress notes: -On 05/11/2024 at 9:03pm, reflected LVN D wrote that she was notified by a CNA that Resident #24 refused care. Resident #24 told LVN D that she was fine and just didn't want anyone touching her crotch without her permission. -On 5/12/24 at 8:15am , LVN C wrote that Resident #24 told her that last night she was upset with staff with inappropriate touching of her crotch and that she does not feel safe with the night shift that was on. Resident #24 also told her she felt safe at that time. -On 5/12/24 at 10:46am , FS Bthe former DON wrote that the resident refused to be changed because she doesn't want anyone touching her in her peri area (resident referred to it as her crotch) without permission. Resident #24 expressed to FS Bthe former DON that she was uncomfortable when the sheet was pulled back so she can be checked for incontinence. Record review of Resident #24's transfer form dated 05/12/2024 revealed she was transferred out of the facility for suicidal ideation. Further review revealed Resident #24 had no skin injuries and used a walker at the time of transfer. Record review of TULIP (portal where facilities report incidents to the state) on 08/19/2024 revealed no facility self-reports for Resident #24 or Resident #45's incidents. Observation of the facility on 8/21/2024 at 10:21am, revealed there was a sign was posted in the front lobby listing the two Abuse Coordinators' contact information, who were the QS and interim Administrator. Interview with the CM on 8/23/24 at 10:38am, he said that Resident #24 complained about the incident the day after on 5/12/24 but that it was related to the CNA being too rough during incontinent care and that she preferred a nurse do it rather than a CNA. The CM denied that Resident #24 implied abuse. The CM said the facility investigated the incident, but does not know the findings. Interview with the QS on 8/23/24 at 11:07am, he said that his job responsibilities as Quality Patient Safety Specialist was were to review incidents and accidents and reporting processes. He said the facility used an escalation algorithm to determine if an incident is reportable to the State, which included reviewing the allegation, interviewing relevant personnel, huddlinge with leaders in the Risk and Legal department and decidinge from there to report or not. When asked about the incident with Resident #24 , heThe QS said he did not remember itthe incident with Resident #24 and said he will would have to defer to his notes. Later the QSLater interview with the QS on 8/23/24 at 12:30pm, came back and said he could not find any documentation related to Resident #24's incident. Interview with the interim Administrator on 8/23/24 at 11:10am, he stated he started working in his current position in July 2024 . He said he was not aware of Resident #24's incident. He said any allegations of abuse should be immediately reported to the HHSC and then investigated. The Administrator said staff are not to report any allegations of abuse to their charge nurse and then to the Abuse Coordinator . (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the VPO on 08/23/2024 at 11:34am, she said she did not remember Resident #24's incident. The VPO stated she was aware that allegations of abuse should be reported within a two-hour timeframe . Interview with the QD on 8/23/24 at 11:49am, she said if a resident reportsresident reports abuse experiencing abuse, the facility does an internal investigation, and if the incident is determined reportable, that's that was when it is reported to the state. The QD said she did not remember Resident #24's incident but that based on the allegations the facility would have reported if they knew. Interview with the former DON on 8/23/24 at 3:02pm, she said she started working at the facility on 5/26/24 and never heard about Resident #24's incident. Interview with the the former Administrator on 8/23/24 at 3:20pm, the former Administrator said and that they remembered Resident #24's incident . They said the facility decided the incident was not reportable due to Resident #24's diagnoses. The former Administrator said that the former DON wrote a clarifying statement in Resident #24's nursing progress notes that left out the part of Resident #24's allegation stating that someone touched her inappropriately. The facility said the resident was delusional and was having a psychotic episode. Attempted interview with CNA C on 08/20/2024 at 12:05pm, left a voicemail. Attempted interview with LVN D on 08/22/24 at 10:58 a.m, left a voicemail. Attempted interview with LVN C on 08/20/2024 at 12:03pm, left a voicemail. 2.Record review of Resident #45's face sheet dated 08/22/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #45 had diagnoses which included: atrial fibrillation (an irregular heartbeat), hypertension (when the pressure in your blood vessels is too high), gastroenteritis (inflammation of the stomach intestinal lining) and colitis (inflammation in the colon). Record review of Resident #45's admission MDS assessment dated [DATE] revealed a BIMS score of 13 of 15 which indicated intact cognition. Further review revealed the resident needed extensive assistance to total assistance with ADLs which required at least one staff assistance. Record review of Resident #45's care plan initiated on 03/29/24 revealed resident had an ADL self-care deficit related to inability to perform activities of daily living independently. Intervention: Requires assistance of staff. Record review of Resident #45's progress note dated 05/16/24wrote by RNA read in part .DON notified writer that patient has complains during therapy session today and wants writer to f/u. Writer interviewed patient and patient notified writer that someone had grabbed both her hands and shoved her in bed last night. Patient proceeded to show writer some bruises on her arms. She pointed to one bruise and said, this is old, but these ones were from yesterday from where I was grabbed, pointing to 2 different bruises. Patient stated Last night a young lady, came to my room, grabbed both my hands and shoved me in bed. I asked the young lady what you are doing? but she did not say anything. Head-to -toe assessment performed on patient. Patient alert and oriented X2-3 with some forgetfulness . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #45's progress note dated 5/16/24 wrote by RN A read in part . notified RP about incident and RP notified writer that she had called patient on Wednesday (05/15/24) morning around 9-10am, and patient had reported the incident to her that someone grabbed her hands and shoved her in bed during the night. RP said that she was waiting to bring it up during the care plan meeting on Friday. Administrator was notified . During an interview on 08/21/24 at 3:33 p.m., RT B said Resident #45 mentioned to him while she was in therapy that a staff grabbed her hand, and it was during transfer. RT B said he told the former DON and the former Administrator at the time. RT B said Resident #45 told him she was grabbed by the forearms and she had discoloration on her arms but was not sure if it was from the incident or not. RT B said the former DON came and assessed the resident, and she took the resident out of the gym and continued to check on Resident #45. During an interview on 08/23/24 at 10:53 a.m., CM said he did not remember any incident with Resident #45. CM said he would research it and notify the surveyor about his findings. During an interview on 08/23/2024 at 11:13 a.m., QS said he could not recall any incident about Resident #45. QS said he would investigate and get back to the surveyor. During an interview on 08/23/24 at 11:19 a.m., the Administrator said he must report to HHSC immediately and then start the investigation. The Administrator stated that if a staff member were identified in the incident, he would suspend the staff member while continuing the investigation. The Administrator said he would also notify Resident #45 physician and the responsible party. The Administrator said they would conduct quality of life and safety questions and in-service on abuse/neglect for the staff. The Administrator said he was unaware of the incident or allegation of abuse complaint by Resident #45 because he was not in the facility then. During an interview on 08/23/24 at 1134 a.m., VPO said she was not sure about Resident #45's alleged abuse, but she would research it and get back to the surveyor. Then, VPO said she thought there was an incident they did huddle about regarding Resident #45, but she was not sure. During an interview on 08/23/24 at 11:49 a.m., QD said she recalled she went and talked to Resident #45, and Resident #45 asked her to look at her arm, and she asked her to tell her how it happened. QD said that Resident #45 did not know how it had happened and that it was purple. QD said Resident #45 said if she bumped into anything, she would get bruised. QD said that the discolorations were not really bruises on Resident #45's arms because she was on a blood thinner, and she could bruise easily. QD said she did not interview RN A or RT B During an interview on 08/23/24 at 12:07 p.m., RN A said she was at the nursing station when the former DON came and told her that Resident #45 complained that somebody was rough with her. RN A said Resident #45 told her the incident happened during the night shift when she went and assessed Resident #45. RN A said Resident #45 told her a staff was rough and pulled her hand and pushed her into the bed, and Resident #45 had bruises on her arms. RN A said when she called Resident #45's family member to tell her about Resident #45's allegation of abuse, the family told her Resident #45 had already called and notified her that the staff had been rough with her a day before. RN A said she called the former Administrator and told her about the alleged abuse, and the former Administrator said she would investigate the allegation of abuse. (continued on next page)

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	675667	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing Center	7480 Beechnut Houston, TX 77074

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/23/24 at 12:30 p.m., QS came back and said he could not find any information about Resident #45's abuse allegation. During an interview on 08/23/24 at 12:44 p.m., VPO returned and said she could not find any information on Resident #45's incident. During an interview on 08/23/24 at 2:44 p.m., the former DON said she remembered; RT B told her Resident #45 complained she was grabbed and pushed into the bed. The former DON said Resident #45 told her a young girl about 16 or [AGE] years old pulled her hands a little harder when she was taking her to the restroom. The former DON said she saw Resident #45's hands and would not call it bruises because it was bleeding under the skin and appeared like purpura (when small blood vessels burst, and blood pools under the skin). The former DON said Resident #45 had it all over her arms and legs, but she pointed to some areas and said these happened last night when she pulled her hands. The former DON said when she reported to the VPO, she told her to stop the investigation and that the team would take over the investigation. During an interview on 08/23/24 at 3:22 p.m., the former Administrator said she heard that Resident #45 said somebody went into the room and grabbed her hands, and RN A did not report the alleged abuse to her but to the VPO. The former Administrator said RN A, who assessed Resident # 45, said she called to notify Resident #45's family member, and the family member said Resident #45 notified her early this week. The former Administrator said that as an administrator, whenever a resident alleged any abuse, it should be reported to HHSC, and then you should investigate. Record review of the facility's Abuse, Neglect and Exploitation Policy published 10/03/2023 revealed that all Agency employees and contractors are required, and have the legal obligation to, report suspected abuse, neglect, and/or exploitation to the Texas Health and Human Services Department of Aging and Disability Services .If there is cause to believe abuse, neglect, or exploitation of a resident has occurred by a facility employee, representative, volunteer or contractor, the incident(s) will be reported to THHS and DADS as per state and federal regulatory requirement, upon witnessing the act or upon receipt of the allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview and record review, the facility failed to have evidence that all alleged violations of abuse are thoroughly investigated and results of the investigation reported to the State Survey Agency within 5 working days of the incident for 2 of 11 (Residents #24 and #45) residents reviewed for Abuse, Neglect, and Exploitation. 1.The facility failed to have evidence that Resident #24's allegations of CNA C touching her groin area without her permission was thoroughly investigated and findings reported. 2.The facility failed to have evidence Resident #45's allegations that on 5/15/24 someone grabbed her hands and shoved her in bed during the night was thoroughly investigated and findings reported. This failure could place residents at risk for abuse and/or neglect by not having their concerns and allegations of abuse thoroughly investigated and reported. Findings included: 1. Record review of Resident #24's Face Sheet dated 08/21/24 revealed a [AGE] year-old who was originally admitted on [DATE] due to healing after a fracture of their third lumbar vertebra. Other medical diagnoses included: hypothyroidism (a condition where the thyroid gland does not produce enough hormones to effectively regulate a person's metabolism), Bipolar Disorder (a mental illness characterized by severe high and low moods and changes to sleep, energy, thinking and behavior; also called manic depression), and Lupus Erythematosus (an autoimmune disease that can affect many body systems, causing rashes, inflammation, fatigue and fever). Record review of Resident #24's care plan last reviewed on 5/9/24 revealed the following focus areas: -Resident #24 has a self-care deficit related to inability to perform activities of daily living independently, with interventions including allowing sufficient time for hygiene, encouraging Resident #24 to participate in hygiene and praise accomplishment as able, monitoring skin daily and weekly as needed, provide and observe resident's privacy and rights at all times. -Resident #24 is on Antidepressant medication related to Bipolar Disorder, with interventions including giving antidepressant medications ordered by physician and monitoring and documenting side effects and effectiveness, and monitoring, documenting, and reporting to the physician ongoing symptoms of depression such as being sad, irritable, crying, shame, suicidal ideations, fatigue, fear of being alone or with others, unrealistic fears, attention seeking, and anxiety. Record review of Resident #24's Comprehensive MDS (resident assessment tool) dated 04/29/2024 revealed a BIMS (brief interview measuring cognitive intactness) score of 14, indicating intact cognition. Further review revealed that Resident #24 was totally dependent on helper(s) for toileting hygiene. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's progress notes: -On 05/11/2024 at 9:03pm, reflected LVN D wrote that she was notified by a CNA that Resident #24 refused care. Resident #24 told LVN D that she was fine and just didn't want anyone touching her crotch without her permission. -On 5/12/24 at 8:15am , LVN C wrote that Resident #24 told her that last night she was upset with staff with inappropriate touching of her crotch and that she does not feel safe with the night shift that was on. Resident #24 also told her she felt safe at that time. -On 5/12/24 at 10:46am , FS Bthe former DON wrote that the resident refused to be changed because she doesn't want anyone touching her in her peri area (resident referred to it as her crotch) without permission. Resident #24 expressed to FS Bthe former DON that she was uncomfortable when the sheet was pulled back so she can be checked for incontinence. Record review of Resident #24's transfer form dated 05/12/2024 revealed she was transferred out of the facility for suicidal ideation. Further review revealed Resident #24 had no skin injuries and used a walker at the time of transfer. Record review of TULIP (portal where facilities report incidents to the state) on 08/19/2024 revealed no facility self-reports for Resident #24 or Resident #45's incidents. Observation of the facility on 8/21/2024 at 10:21am, revealed there was a sign was posted in the front lobby listing the two Abuse Coordinators' contact information, who were the QS and interim Administrator. Interview with the CM on 8/23/24 at 10:38am, he said that Resident #24 complained about the incident the day after on 5/12/24 but that it was related to the CNA being too rough during incontinent care and that she preferred a nurse do it rather than a CNA. The CM denied that Resident #24 implied abuse. The CM said the facility investigated the incident, but does not know the findings. Interview with the QS on 8/23/24 at 11:07am, he said that his job responsibilities as Quality Patient Safety Specialist was were to review incidents and accidents and reporting processes. He said the facility used an escalation algorithm to determine if an incident is reportable to the State, which included reviewing the allegation, interviewing relevant personnel, huddlinge with leaders in the Risk and Legal department and decidinge from there to report or not. When asked about the incident with Resident #24 , heThe QS said he did not remember itthe incident with Resident #24 and said he will would have to defer to his notes. Later the QSLater interview with the QS on 8/23/24 at 12:30pm, came back and said he could not find any documentation related to Resident #24's incident. Interview with the interim Administrator on 8/23/24 at 11:10am, he stated he started working in his current position in July 2024 . He said he was not aware of Resident #24's incident. He said any allegations of abuse should be immediately reported to the HHSC and then investigated. The Administrator said staff are not to report any allegations of abuse to their charge nurse and then to the Abuse Coordinator . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the VPO on 08/23/2024 at 11:34am, she said she did not remember Resident #24's incident. The VPO stated she was aware that allegations of abuse should be reported within a two-hour timeframe . Interview with the QD on 8/23/24 at 11:49am, she said if a resident reportsresident reports abuse experiencing abuse, the facility does an internal investigation, and if the incident is determined reportable, that's that was when it is reported to the state. The QD said she did not remember Resident #24's incident but that based on the allegations the facility would have reported if they knew. Interview with the former DON on 8/23/24 at 3:02pm, she said she started working at the facility on 5/26/24 and never heard about Resident #24's incident. Interview with the the former Administrator on 8/23/24 at 3:20pm, the former Administrator said and that they remembered Resident #24's incident . They said the facility decided the incident was not reportable due to Resident #24's diagnoses. The former Administrator said that the former DON wrote a clarifying statement in Resident #24's nursing progress notes that left out the part of Resident #24's allegation stating that someone touched her inappropriately. The facility said the resident was delusional and was having a psychotic episode. Attempted interview with CNA C on 08/20/2024 at 12:05pm, left a voicemail. Attempted interview with LVN D on 08/22/24 at 10:58 a.m, left a voicemail. Attempted interview with LVN C on 08/20/2024 at 12:03pm, left a voicemail. 2.Record review of Resident #45's face sheet dated 08/22/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #45 had diagnoses which included: atrial fibrillation (an irregular heartbeat), hypertension (when the pressure in your blood vessels is too high), gastroenteritis (inflammation of the stomach intestinal lining) and colitis (inflammation in the colon). Record review of Resident #45's admission MDS assessment dated [DATE] revealed a BIMS score of 13 of 15 which indicated intact cognition. Further review revealed the resident needed extensive assistance to total assistance with ADLs which required at least one staff assistance. Record review of Resident #45's care plan initiated on 03/29/24 revealed resident had an ADL self-care deficit related to inability to perform activities of daily living independently. Intervention: Requires assistance of staff. Record review of Resident #45's progress note dated 05/16/24wrote by RNA read in part .DON notified writer that patient has complains during therapy session today and wants writer to f/u. Writer interviewed patient and patient notified writer that someone had grabbed both her hands and shoved her in bed last night. Patient proceeded to show writer some bruises on her arms. She pointed to one bruise and said, this is old, but these ones were from yesterday from where I was grabbed, pointing to 2 different bruises. Patient stated Last night a young lady, came to my room, grabbed both my hands and shoved me in bed. I asked the young lady what you are doing? but she did not say anything. Head-to -toe assessment performed on patient. Patient alert and oriented X2-3 with some forgetfulness . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #45's progress note dated 5/16/24 wrote by RN A read in part . notified RP about incident and RP notified writer that she had called patient on Wednesday (05/15/24) morning around 9-10am, and patient had reported the incident to her that someone grabbed her hands and shoved her in bed during the night. RP said that she was waiting to bring it up during the care plan meeting on Friday. Administrator was notified . During an interview on 08/21/24 at 3:33 p.m., RT B said Resident #45 mentioned to him while she was in therapy that a staff grabbed her hand, and it was during transfer. RT B said he told the former DON and the former Administrator at the time. RT B said Resident #45 told him she was grabbed by the forearms and she had discoloration on her arms but was not sure if it was from the incident or not. RT B said the former DON came and assessed the resident, and she took the resident out of the gym and continued to check on Resident #45. During an interview on 08/23/24 at 10:53 a.m., CM said he did not remember any incident with Resident #45. CM said he would research it and notify the surveyor about his findings. During an interview on 08/23/2024 at 11:13 a.m., QS said he could not recall any incident about Resident #45. QS said he would investigate and get back to the surveyor. During an interview on 08/23/24 at 11:19 a.m., the Administrator said he must report to HHSC immediately and then start the investigation. The Administrator stated that if a staff member were identified in the incident, he would suspend the staff member while continuing the investigation. The Administrator said he would also notify Resident #45 physician and the responsible party. The Administrator said they would conduct quality of life and safety questions and in-service on abuse/neglect for the staff. The Administrator said he was unaware of the incident or allegation of abuse complaint by Resident #45 because he was not in the facility then. During an interview on 08/23/24 at 1134 a.m., VPO said she was not sure about Resident #45's alleged abuse, but she would research it and get back to the surveyor. Then, VPO said she thought there was an incident they did huddle about regarding Resident #45, but she was not sure. During an interview on 08/23/24 at 11:49 a.m., QD said she recalled she went and talked to Resident #45, and Resident #45 asked her to look at her arm, and she asked her to tell her how it happened. QD said that Resident #45 did not know how it had happened and that it was purple. QD said Resident #45 said if she bumped into anything, she would get bruised. QD said that the discolorations were not really bruises on Resident #45's arms because she was on a blood thinner, and she could bruise easily. QD said she did not interview RN A or RT B During an interview on 08/23/24 at 12:07 p.m., RN A said she was at the nursing station when the former DON came and told her that Resident #45 complained that somebody was rough with her. RN A said Resident #45 told her the incident happened during the night shift when she went and assessed Resident #45. RN A said Resident #45 told her a staff was rough and pulled her hand and pushed her into the bed, and Resident #45 had bruises on her arms. RN A said when she called Resident #45's family member to tell her about Resident #45's allegation of abuse, the family told her Resident #45 had already called and notified her that the staff had been rough with her a day before. RN A said she called the former Administrator and told her about the alleged abuse, and the former Administrator said she would investigate the allegation of abuse. (continued on next page)

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University Place Nursing Center	7480 Beechnut Houston, TX 77074

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/23/24 at 12:30 p.m., QS came back and said he could not find any information about Resident #45's abuse allegation. During an interview on 08/23/24 at 12:44 p.m., VPO returned and said she could not find any information on Resident #45's incident. During an interview on 08/23/24 at 2:44 p.m., the former DON said she remembered; RT B told her Resident #45 complained she was grabbed and pushed into the bed. The former DON said Resident #45 told her a young girl about 16 or [AGE] years old pulled her hands a little harder when she was taking her to the restroom. The former DON said she saw Resident #45's hands and would not call it bruises because it was bleeding under the skin and appeared like purpura (when small blood vessels burst, and blood pools under the skin). The former DON said Resident #45 had it all over her arms and legs, but she pointed to some areas and said these happened last night when she pulled her hands. The former DON said when she reported to the VPO, she told her to stop the investigation and that the team would take over the investigation. During an interview on 08/23/24 at 3:22 p.m., the former Administrator said she heard that Resident #45 said somebody went into the room and grabbed her hands, and RN A did not report the alleged abuse to her but to the VPO. The former Administrator said RN A, who assessed Resident # 45, said she called to notify Resident #45's family member, and the family member said Resident #45 notified her early this week. The former Administrator said that as an administrator, whenever a resident alleged any abuse, it should be reported to HHSC, and then you should investigate. Record review of the facility's Abuse, Neglect and Exploitation Policy published 10/03/2023 revealed that all Agency employees and contractors are required, and have the legal obligation to, report suspected abuse, neglect, and/or exploitation to the Texas Health and Human Services Department of Aging and Disability Services .If there is cause to believe abuse, neglect, or exploitation of a resident has occurred by a facility employee, representative, volunteer or contractor, the incident(s) will be reported to THHS and DADS as per state and federal regulatory requirement, upon witnessing the act or upon receipt of the allegation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for 2 (Residents #47, #12) of 4 residents reviewed for pharmacy services. The facility failed to ensure Resident #47, Procrit was available for administration according to the physician. The facility failed to ensure Resident #12 Paxlovid was available from administration according to the physician's order. This deficient practice could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication. Findings include: Record review of Resident #47's face sheet dated 08/21/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE]. Resident #47 had diagnoses which included: atrial fibrillation (an irregular heartbeat), anemia (did not have normal amount of red blood cells), and chronic kidney disease stage 5 (kidneys are getting very close to failure or have already failed). Record review of Resident #47's admission MDS assessment dated [DATE] revealed a BIMS score of 15 of 15 which indicated intact cognition. Further review revealed the resident needed moderate to extensive assistance with ADLs which required at least one staff assistance. Record review of Resident #47's care plan initiated on 06/26/24 revealed resident had an ADL self-care deficit related to inability to perform activities of daily living independently. Intervention: Requires assistance of staff. Record review of Resident #47's clinical physician orders read in part . Epoetin Alfa Injection Solution 10000 UNIT/ML (Epoetin Alfa) Inject 10000 unit subcutaneously one time a day every Wed, Thu for anemia Pharmacy Discontinued 7/24/2024 08:00 7/24/2024 ordered 7/23/2024 . Record review of Resident #47's MAR dated July 2024 read . Epoetin Alfa Injection Solution 10000 UNIT/ML (Epoetin Alfa) Inject 10000 unit subcutaneously one time a day every Wed, Thu for anemia -Start Date-07/24/2024 0800 -DIC Date-)7/24/2024 2020 . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of LVN B statement dated 08/01/24 read in part . Resident #47 requested for the Epoetin injection and NP B was notified and she gave for the epoetin on 07/23/24 to be administered once a week. When the medication was not delivered she called the pharmacy on 07/24/24 and the pharmacy request Resident #47's lab and it was faxed to the pharmacy on 07/24/24. The medication was not delivered on 07/24/24,then she called the pharmacy on 07/25/24 and she was told the medication was a high cost medication and a form would have been faxed over to the facility to be filled out before the medication could be sent to the facility. LVN B wrote she checked the fax machine and she did not see the form and she notified the night nurse . During an interview on 08/21/24 at 1:08 p.m., the Administrator said Resident #47's physician gave the order for Procrit (Epoetin alfa), and it was supposed to come on the next run(the next delivery after the medication had been sent to the pharmacy), but it did not because it was a high-cost medication. LVN B did not escalate to the next level supervisor when the medication did not arrive from the pharmacy. The Administrator said LVN B did not escalate to the DON and him after she called the pharmacy when she did not receive the preauthorization form for high-cost medications, and it delayed the delivery of the medicines for Resident #47 and the medication was not delivered until seven days later, but Resident #47 did not miss any dose. The Administrator said that when he was made aware of the incident on 07/29/24(Resident #47 medication had not been delivered), he became involved and signed the preauthorization form. The Administrator said the facility had taken corrective action because they had increased the money for high-cost medications from $500 to $5000. The Administrator said the incidents had been QAPIED, and in services, the nurses and the management team met with the pharmacy company. During an interview on 08/21/24 at 2:21 p.m., NP B said Resident #47 went to the renal doctor, who told her to start on Procrit injection. NP B said she called Resident #47's nephrologist for the medication order, and she did not send the order. NP B said when the nephrologist did not return her call or send the order, she ordered the Procrit. NP B said the facility notified her, but she did not know what day the facility notified her. NP B said the facility told her they had not received the medication from the pharmacy. NP B said she did not remember ordering the medication to be given on 07/24 and then continuing every week because she was responding from memory. During an interview on 08/21/24 at 2:30 p.m., FP A said the medication for Resident #47 was not ordered as a stat(without delay) order because the medication takes about a week to two weeks to start working. FP A said Resident #47 was in a hemodynamics emergency(when the blood flow is unstable); she would have been sent to the hospital for blood transfusions. FP A read Resident #47's hemoglobin from the lab website: 07/22 was 7.2 at the hospital, and she was sent back to the facility; on 07/25/24, it was 6.3, and on 7/29/24, it was 6.9(the numbers for the hemoglobin in the blood and it is a protein in the red blood cells that carries oxygen throughout the body and returns carbon dioxide to the lungs). FP A said the facility notified him that Resident #47's Procrit was not delivered on time, and they had QAPI. FP A stated the facility had put other actions in place, and the nurses were in serviced. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 9:19 a.m., the CM said the facility did a cart audit, and the pharmacy technician did it, and the audit was done daily. The MC said he was the person who called the pharmacy to send Procrit for Resident #47 when he became aware of the high dollar cost of the medication. The CM said he was the person who notified the administrator, and the administrator signed the preauthorization form for Resident #47's Procrit. The CM said the action plan was done for Resident #47's medication; only the nurses were in serviced on the escalation process about medications not being available due to high cost, and the threshold was increased to $5000.00. The CM said he monitored the medication daily for both new admissions and newly prescribed medication. The CM said there was a hiccup on how to get high-threshold medicines, and they had talked to the pharmacy about it. The pharmacy said they are retraining their staff. The CM said the Procrit was ordered on 07/23/24, and the pharmacy said it was a high-cost dollar medication and needed a preauthorization form, and they requested Resident #47's lab, too. The CM stated that the pharmacy had faxed the preauthorization form. The nurse kept communicating with the pharmacy that they did not receive the form for authorization. The CM said the nurse failed to escalate to the next level of management until the seventh day, when he became aware the pharmacy did not deliver the medication and took care of it. During an interview on 08/22/24 at 10:37 a.m., LVN B said she did not have anything to add to the statement she wrote. LVN B said the pharmacy asked her to fax Resident #47's lab, and she faxed it, and they told her it was a high-cost medication. LVN B said the pharmacy said they would send a form for the facility to fill out, and she got busy and forgot, but she checked the fax later, and apparently, the pharmacy did not send the form. LVN B said she called the pharmacy back, and still no form. LVN B said she did not know when to escalate to the DON, maybe within 2 hours, and she did not because she was busy taking care of the residents. LVN B said she had no in-service about reporting if the medication was not delivered or escalated to the next-level manager. LVN B said Resident #47 could have had a negative outcome because it took a long time for the injections to come. During an interview on 08/22/24 at 2:56 p.m., RP A said he was contacted by the facility when the pharmacy delayed the delivery of the Procrit for about a week. RP A stated there were a couple of things that caused the delay: the dispensing pharmacy needed to know Resident #47's hemoglobin and if the resident was a dialysis resident, and the medication was a high-cost medication and needed the facility to sign the authorization form and that was how the medication was delayed. RP A said the pharmacy made several attempts to get Resident #47's information and signed the preauthorization form. RP A said LVN B was communicating with the pharmacy, and the pharmacy said they had the fax number and how many times they reached out to the facility, but LVN B did not escalate to the next level supervisor, which caused the delay for the medication to be delivered. RP A said the facility had taken some steps to prevent this incident from happening again by increasing the high-cost medication from $500 to $5000. RP A said the break he saw in this incident was a break in the escalation to the next-level supervisor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675667	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Place Nursing Center	7480 Beechnut Houston, TX 77074

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 08/22/24 at 3:26 p.m., RP B said the pharmacy first received the medication for Resident #47 on 07/23/24 at 1:59 p.m., Procrit 10000unit SUB Q, one time a day Wednesday, every Thursday. RP B said to fill the medication, the insurance required Resident #47's hemoglobin level and if the resident was on dialysis. RP B said there was no billing information when the pharmacy received the order, and it went into limbo, which was the pharmacy's mistake. On 07/24/24 at 10:10 a.m., the pharmacy tried contacting the facility about Resident #47's dialysis status. It was told to the pharmacy that Resident #47 was not on dialysis at 11:10 a.m., then they sent out the form at 11:11 a.m., 11:45 a.m., 12:46 p.m., the same day, again at 4:17 p.m., and the pharmacy did not receive the form back from the facility. RP B said the next day (07/25/24), the billing department sent out another form at 9:41 a.m. and 9:48 a.m., and the facility did not respond. Then, on 09/29/24 at 2:29 p.m., they received the form from LVN C the pharmacy did not have Procrit, and they had to get approval for Epogen, so they called the facility at 4:18 p.m., and told LVN C that they have the medication and the medication was sent out to the facility stat(quickly) at 4:51 p.m. RP B said since then, they had received the phone numbers for all the supervisors up to the VP to communicate so that the mistake would not be repeated. RP B said the facility's mistake was they did not understand the contract(the agreement between the facility and the pharmacy on high cost medication) the facility signed in 2015. During an interview on 08/22/24 at 5:36 p.m., with VPO, QD, and the Administrator, VPO said they had QAIP for the incidents and identified the RCA, and each area was assigned to individuals that would work on it and the time frame. VPO said the root cause was the nurses did not escalate when medication was not delivered. The, following was put in place: staff education on a time frame for medication being obtained and coordinating medication procurement. QD said the training is ongoing, and they had trained about 90% of the staff, and it was done in the facility and online. VPO said they had a meeting with the pharmacy company and increased the threshold from $ 500 to $5000. VPO said they implemented the improvement plan in relation to escalation (PIP). VPO said the pharmacy would call the facility within 30 minutes of receiving the script, the nurse would review missing medication during shift change, and it would be discussed during stand-up meetings. VPO said the missed medication would be assessed to a department head (DON or Clinical manager) to follow up with missed medications. VPO said the clinical manager would go and talk to the nurse to see if the medication was missed, if the physician and family were notified, and if it was truly missed or a documentation error. VPO said the facility started to run missed medication report daily after the incidents to avoid missed medication because the medication was expensive. During an interview on 08/22/24 at 6:14 p.m., QD said she believed the break happened when LVN B was waiting for the fax to come over, and that was the biggest barrier. QD said LVN B should have escalated the incident when the medication did not come. QD said there was no negative outcome for Resident #47. QD said LVN B did not attend the in-service because she had not worked since the incident. During an interview on 08/22/24 at 6:22 p.m., the VPO said the problem was escalation from LVN B. Now, the nurses have been instructed to escalate to the next-level supervisor if any medication is not delivered on the next medication run. The pharmacy has the phone numbers of all department heads and an email. The VPO said the pharmacy has to email any fax information, and the management will review and follow up on the communication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #12's face sheet dated 08/21/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE]. Resident #12 had diagnoses which included: fracture neck of left femur (top part of the leg bone is broken just below the ball and socket joint), COVID 19 (highly contagious respiratory disease cause by the SARS (CoV -2 virus), and hypertension (the pressure in the blood vessels is high). Record review of Resident #12's admission MDS assessment dated ,d+[DATE] revealed a BIMS score of 15 of 15 which indicated intact cognition. Further review revealed the resident needed moderate to extensive assistance with ADL's which required at least one staff assistance. Record review of Resident #12's care plan initiated on 07/28/24 revealed resident requires care and isolation due to the covid 19. Intervention: Staff to administer medication as ordered and monitor for effectiveness Record review of Resident #12's clinical physician orders read in part . Paxlovid (150/100)oral tablets therapy packet 10x150mg give 2 tablet by mouth two times a day for 5 days .order date 07/27/24 Record review of Resident #12's MAR dated July 2024 read Paxlovid (150/100) Oral Tablet Therapy pack 10 x 150 MG & 10 x 100MG, Give 2 tablet by mouth two times a day for COVID for 5 Days. start date 07/27/24, discontinued 07/29/24 . it also revealed the medication was not administered to Resident # 12 until it was discontinued on 07/29/24. Record review of Resident #12's progress note dated 07/25/24 by FP B read in part .Improving - New acute weakness today - Concerning for infection - Stat CBC, CMP, covid test . During an interview on 08/21/24 at 1:08 p.m., the Administrator said the hiccup about the COVID medication for Resident #12 was the 3-day window was missed because the medication was not delivered on time because it was high cost and the nurse did not escalate to the next level supervisor timely. The Administrator said Resident #12 could have had a negative outcome because the medication was not administered as ordered. During an interview on 08/21/24 at 4:49 p.m., CM said Resident #12's Paxlovid was ordered on the weekend(07/27/24), and the pharmacy said that it was a high-dollar medication and it needed preauthorization. CM said three nurses documented that they were following up with the pharmacy. LVN C notified him at some time on 07/28/24, and he told LVN C to notify the administrator. CM said the effectiveness of the medication would be most beneficial if the medication was given within the first five days of signs and symptoms of COVID to decrease the negative effects of COVID, such as SOB and muscle ache, and prevent a resident from becoming very sick. CM said there could be a negative outcome because the S/S would been prolonged. CM said when the medication was approved, it had been more than 5 days, and the doctor discontinued it because it had passed the 5-day window. CM said Resident #12 had a fever on Wednesday(07/24/24). CM then said Resident #12 had S/S on either Tuesday or Wednesday, and they did a PCR(polymerase chain reaction) test, which was sent to the hospital, and the hospital said they lost the PCR test.CM said the test was repeated on Friday, and it was positive on Saturday; CM said FP B ordered the COVID medication on a Saturday and was not filled until Monday (07/29/24), but FP B discontinued the medication because the window had passed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 5:18 p.m., FP B said she saw Resident #12 on 07/25/24, and Resident #12 said she was coughing, and everybody was coughing, and she ordered stat CBC and COVID test. FP B said she called the facility on Friday (07/26/24) and was told the lab lost the COVID test. She ordered another COVID test, and the result came back positive. FP B said the on-call doctor gave the order for Paxlovid. FP B said she was not aware Resident #12 had not started on the medication because the facility could not get it because it was a high-cost medication until she came to the facility around 2:00 p.m. on 07/29/24. FP B said even if the facility told the night on-call physician on 07/28/24, she gave the order to hold the medication. FP B said it did not mean the facility should not have the medication delivered to the facility. FP B said the facility got the medication late on Monday(07/29/24), and she gave an order not to administer it because the facility did not get the medication within the window where it would be beneficial for Resident #12. FP B said Resident #12 could have had a blood clot because her medication was not administered, and she was in pain, and Resident #12 had comorbidities that predisposed her to more negative outcomes. During a telephone interview on 08/22/24 at 3:26 p.m., RP B said the physician transmitted the order for Paxlovid to the pharmacy on 07/27/24 at 10:02 a.m. RP B said the medication was put into the system at 10:04 a.m., cost $1500, and was no longer covered by the government. RP B said the facility was notified about the Paxlovid application for the assistant program on 07/27/24 at 5:52 p.m. RP B said the assistant program held the medication approval for about a day and a half before they responded that it was not approved on 07/28/24 at 12:48 p.m. RP B said the facility was notified at the same time that the medication was pending for approval. RP B stated that the medication was not approved again on 07/29/24 at 10:30 a. m. Then the facility said they had obtained it from another pharmacy, and LVN C canceled(told the pharmacy not to deliver the medication) around 4:10 p.m. RP B stated the facility had changed the threshold from $500 to $5000. During an interview on 08/22/24 at 9:19 a.m., CM said Resident #12's Paxlovid medication happened about the same time as Resident #47's Procrit, and it was he who notified the administrator on 07/29/24 that resident #47 and Resident #12 had not received their medications because it was a high cost medication and the authorization had not been sighed. CM said the nurses were trained and in serviced on escalation and pre authorization , before the incident and after both incidents. During an interview on 08/21/24, 08/22/24, and 08/23/24 between 12:07 p.m. and 4:11 p.m., LVN A, RN D, RN F, RN A, and MA O said they had an in-service on how to escalate to the next supervisor if any medication was not delivered with the next medication run and the medication was not in the E kit(emergency medication kit). They said if medication required authorization, they had to escalate to the next level supervisor and continue communication between the pharmacy and supervisor. Record review of facility policy on medication and treatment order dated 12/15/23 read in part . to ensure accurate, safe, and effective administration of prescribed medications . It further read, all orders for medications must include all the elements of a complete and clear medication order, including start and stop date, dosage and frequency of administration . 48923