STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675848	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Webster	17231 Mill Forest Webster, TX 77598

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48315 Based on observation , interview, and record review the facility failed to ensure the resident's had the right to have reasonable access to the use of telephone and a place in the facility where calls can be made without being without being overheard for 1 of 3 (Resident #1) residents reviewed for communication. The facility failed to provide a place for Resident #1 to make telephone calls without being overheard. Observation of Resident #1 using the phone at nursing station while (3) nurses were at the nurse station and (2) other resident's at the nurse station receiving medication. This failure could place residents at risk of conversation being overheard and privacy right's not being respected and could result in a decline in resident's psychosocial well-being and quality of life. Findings include: Record review of Resident #1 admission face sheet dated 01/14/2021 reflected a [AGE] year-old male admitted on [DATE]. Record review of Resident #1's History and Physical dated 01/28/23 revealed diagnosis of depression (a common mental health condition characterized by persistent low mood, loss of interest or pleasure in activities, and other symptoms that interfere with daily functioning.) Record review of Resident #1's MDS dated [DATE] revealed a BIMS of 14 indicating the resident was cognitively intact. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During Interview with Resident #1 on 1/28/2025 at 10:30AM. Resident #1 said he called his friends or family on the phone at the nursing station he was told that is the only place to make a telephone call or if you have a cell phone. Resident #1 said the facility does not have a cordless phone to use and most of my conversations are heard by the nurses or anyone walking by. Resident #1 said we only get 15 minutes due to the nursing staff needing to use the phone. Resident #1 said he had not been offered any other phone to use in private. Resident #1 said he knows how to use the phone however staff will call the number for him. Resident #1 said he does not feel secure in his conversations and speaking in an open area, and he knows the nurse can hear his conversation. Resident #1 said it makes him feel like he does not have any privacy. During Interview with DON on 1/28/2025 at 11:20 am the DON said the nurse's station is the only area for residents to use the phone. Many of the alert residents have their own personal cell phones. The DON said unfortunately we do not have an area for the Residents to use for privacy. During Interview with facility Administrator on 1/28/2025 at 12:00 pm the Administrator said the residents are able to use the phone at the nurse station or at the receptionist desk if need be. He stated I have a phone by my office that they can use also but as of now we do not have designated area for the resident to use, we are currently working on that. The Administrator said the facility did not have a policy on resident phone use and privacy.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on Record review and interview, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS System for 2 (Resident #15, Resident #56) of 18 residents reviewed for MDS transmission, in that: -The facility failed to transmit a completed Admission MDS assessment for Resident #15 - The facility failed to ensure Resident #56's Significant change MDS Assessment was completed within 14 days significant change. This failure could place residents at-risk of not having their assessments completed timely, which could result in denial of services and or payment for services. Findings include: Findings include. Record review of Resident #15's face sheet dated 01/29/25 revealed Resident #15 was a [AGE] year-old female, with an original admitted [DATE] and re admitted on [DATE]. Her diagnosis included acute pyelonephritis (A sudden and severe inflammation of kidney due to a bacterial infection). Muscle wasting, Hypothyroidism (a condition where the thyroid gland does not make enough hormone) communication deficit (Difficulty in communication that arises from impairments in cognitive process), unspecified lack of coordination, Unsteady feet. Record review of Resident #15's Admission MDS dated [DATE] was completed 02/13/25 which was 20 days after admission. Resident #56 Record review of Resident #56's face sheet dated 01/27/25 revealed Resident #56 was a [AGE] year-old female, with an original admitted [DATE] and re admitted on [DATE]. Her diagnosis included Respiratory failure, muscle wasting, hypothyroidism, Hypothyroidism (a condition where the thyroid gland does not make enough hormone) and depression. Record review of Resident #56's significant change MDS dated [DATE] was signed as completed on 09/17/24 53 days after significant change MDS. During an interview on 01/29/25 at 2:00PM, the MDS coordinator said she was not present at the facility during the time of the MDS assessment. She said the facility did an audit and was aware of the late MDS and had a plan of correction in place. She said she was responsible for ensuring that all MDS reflected resident's condition and are transmitted within a certain time frame. She said not completing the MDS in a timely manner could result in care plan not being completed and delay in care and services as well as denial of payment for services by payor source. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 01/28/24 at 4:00PM , she said she was not trained to sign the MDS and there was a Cooperate staff that signed off on the MDS. Policy on MDS completion and transmission was requested on 01/29/24 at 4:00 PM. MDS coordinator said she follows the RAI manual

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036 Based on observation, interview and record review, the facility failed to ensure that parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders and consistent with professional standards for 1 (Resident #286) of 2 residents reviewed for intravenous fluids. The facility failed to ensure that the dressing on Resident #286's mid-line intravenous line (a short flexible tube inserted into a vein to administer fluids and medications) was changed according to the doctor's order and facility's standard of care. The failure could place residents at risk of infections. Findings include: Record Review of Resident 286's face sheet dated 1/30/25, revealed resident is a [AGE] year old female admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Urinary Tract Infection, Type 2 Diabetes and Unspecified Systolic (Congestive) Heart Failure. Record review of Resident 286's quarterly MDS dated [DATE] revealed a BIMS score of 13 that suggests that Resident 286's cognition is intact. Record review of Resident 286's order summary report dated 1/27/25 reflected the following orders: Mid line dressing and cap change weekly using sterile technique per protocol as needed with an order and start date of 01/20/2025. Mid line dressing and cap change weekly using sterile technique per protocol one time a day every Mon for prophylaxis with order date of 1/20/25 and start date of 1/27/25. Record review of Resident 286's care plan with an admitted [DATE] revealed focus that resident is on antibiotic(s) and is at risk for adverse reactions. Record review of Resident 286's January medication and treatment administration record printed on 1/30/25 revealed that there were no mid line dressing and cap changes documented during 1/20-1/26/25. Per treatment administration record Resident 286 was monitored for signs and symptoms of infection every 8 hours from 1/20-1/30/25. Record review of Resident 286's January medication and treatment administration record printed on 1/30/25 revealed that Resident 286 received IV antibiotics (Meropenem) and Metronidazole every 8 hours as from 1/20-1/27/25. Observation of Resident 286 on 1/27/25 at 11:55 a.m., revealed resident was in her room, lying in bed. Resident was observed to have a midline to her right upper arm with dressing dated 1/18/25. Interview with LVA A on 1/27/25 at 11:55 a.m. revealed that she also confirmed that Resident 286's midline dressing was dated 1/18/25. LVA A stated that Resident 286's midline dressing should have been changed around 1/26/25 and that night shift usually changes the IV dressings. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON on 1/27/25 at 3:36 p.m. revealed that they do not have a policy for midline dressing changes and the competency is the only form they have. The DON confirmed that IV dressing changes should be completed every five to seven days per facility's competency. Interview of DON on 1/29/25 at 11:06 a.m. revealed that IV dressing changes are to be done every five to seven days and the nurse is responsible with the practice being the night shift changes the IV dressings. Record review of the facility's competency assessment for peripheral IV dressing changes revealed that dressings are to be changed at least every 5 to 7 days.

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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** 51036 Based on observation, interview and record review, the facility failed to provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement described in S483.70(f) for 1 (Resident #3) of 5 residents reviewed for pharmacy services. The facility failed to provide Mucinex DM as ordered for Resident #3. The failure could place residents at risk of receiving less than therapeutic benefits from medications. Findings include: Mucinex DM is a medication that has two ingredients which are guaifenesin and dextromethorphan. Guaifenesin is a medication that helps to clear chest congestion and dextromethorphan is a cough suppressant that relieves cough. Resident #3 was given only guaifenesin instead of Mucinex DM. Record review of Resident 3's Progress Notes dated 1/28/25 at 5:02 p.m. revealed that LVN B spoke to the resident's NP and that new order was received to discontinue Mucinex DM and restart Guaifenesin 400 mg oral twice a day routine for cough and congestion. Record Review of Resident 3's face sheet dated 1/30/25 revealed resident is a [AGE] year old male admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke), Dysphagia (difficulty swallowing), Type 2 Diabetes Mellitus, Hypertensive Disease with Heart Failure with history of acute upper respiratory infection and acute bronchitis. Record review of Resident 3's quarterly MDS dated [DATE] revealed a BIMS score of 15 that suggests Resident #3's cognition is intact. Record review of Resident 3's January Medication Administration Record printed on 1/30/25 revealed Mucinex DM Oral Tablet Extended Release 12 Hour 30-600 mg (Dextromethorphan-Guaifenesin) Give 1 tablet by mouth every 12 hours for Cough and congestion for 7 days with a start date of 1/22/25 at 9 a.m. and discontinue date of 1/28/25 at 4:57 p.m. Mucinex DM was documented as being administered from 1/22-1/27/25 at 9 a.m. and 9 p.m. and on 1/28/25 at 9 a.m. Record review of Resident 3's Care Plan provided on 1/30/25 revealed a focus that Resident 3 is at risk for frequent infections related to diabetes mellitus with goal that Resident 3 will have no complications related to diabetes through the review date. Observation of Resident 3's medication administration on 1/28/25 at 8:23 a.m. revealed that Resident 3 was administered guaifenesin 400 mg for order of Mucinex DM Oral Tablet Extended Release 12 Hour 30-600 mg (Dextromethorphan-Guaifenesin) Give 1 tablet by mouth every 12 hours by CMA A. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview of CMA A on 1/28/25 at 12:54 p.m. revealed that the process to order over the counter medications that are needed is to write the medication needed on a paper and give to the person who is over central supply. CMA A stated that over the counter medications are ordered twice a month. Observation of the facility's medication room on 1/28/25 at 1:01 p.m. accompanied by CMA A revealed that no Mucinex DM could be found with the over the counter medications stock. Interview of LVN B on 1/28/25 at 1:02 p.m. revealed that she was not aware that Resident #3 was receiving guaifenesin 400 mg instead of Mucinex DM and that the Mucinex DM was not in stock. LVN B said that when Mucinex DM was first ordered she found a box of Mucinex DM and had given it to the CMA. LVN B said that Resident #3 had been taking guaifenesin 400 mg for years and it was changed to Mucinex DM for seven days last week when resident got sick. Interview of Central Supply/Transportation on 1/28/25 at 1:10 p.m. revealed that staff will notify her when medications are not in stock. Central Supply/Transportation said that orders are placed once a week on Mondays, but she can run to a local pharmacy to purchase medications if needed. Observation of the facility's medication room on 1/28/25 at 1:25 p.m. accompanied by Central Supply/Transportation. No Mucinex DM could be found in the medication room with the assistance of Central Supply/Transportation. Interview of Central Supply/Transportation on 1/28/25 at 1:25 p.m. revealed that Mucinex DM was ordered and was suppose to be delivered last week but was delayed due to the winter storm that occurred on 1/21/25. Observation of 100 hallway medication cart on 1/28/25 at 4:55 p.m. with CMA A revealed that no Mucinex DM could be found with either the over the counter medications or with Resident #3's medications from the pharmacy. Interview of Central Supply/Transportation on 1/29/25 at 9:21 a.m. revealed that she will notify the DON and administrator if the supply truck does not arrive. Central Supply/Transportation said that if the supply truck does not arrive that she will reach out to sister facility for supplies. Central Supply/Transportation said that she makes the orders on Monday and the truck usually comes on Tuesday but she will wait a day before checking on the order. Central Supply/Transportation said she reached out on 1/22/25 regarding the order that should have arrived on 1/21/25 and was told the truck should arrive by 1/23-1/24/25 and by 1/27-1/28/25 at the latest. Central Supply/Transportation said the truck arrived early this morning on 1/29/25. Interview of DON on 1/29/25 at 11:06 a.m. revealed that the central supply person orders the over the counter medication after she is given a list from staff and that they inventory the over the counter stock as well. The DON stated that if there is a new order then the central supply person can go purchase the medication from a local pharmacy if needed. Interview with LVN C on 1/29/25 at 11:22 a.m. revealed she could not remember administering specific medication to Resident #3 but was not aware of him missing any medications. LVN C said she was responsible for refiling missing medications from medication cart if needed. LVN C said she would check the over the counter medication stock and the automated medication dispensing system if she was unable to find a medication that was ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview of CMA B on 1/29/25 at 11:45 a.m. revealed that if she needs an over the counter medication then she will check the medication room and if she is unable to find the medication that she would notify the charge nurse. CMA B said she would make a list for Central Supply/Transportation and give them the list directly. Record review of facility's policy House Supplied (Floor Stock) Medications revealed that the facility may maintain a supply of commonly used over-the-counter (OTC) medications considered floor stock or house medications (not resident-specific), to be administered only upon receipt of an order from an authorized prescriber. Record review of facility's policy General Guidelines for Medication Administration revealed that the facility is to have a sufficient medication distribution system to ensure safe administration of medications with unnecessary interruptions.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39977 Based on observations, interviews, and record review, the facility failed to ensure that S483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay for 1 of 10 residents (Residents #70) reviewed for dental services. -The facility failed to assist in providing emergency or routine dental services in a timely manner. -The facility failed to promptly within 3 days, refer Resident #70 for dental services related to lost dentures. -The facility failed to provide documentation of the extenuating circumstances that led to the delay in Resident #70 being seen by a dentist. These failures could place residents at risk of oral complications, dental pain, and diminished quality of life. Findings included: Resident #70 Review of Resident #70's Admission Record revealed she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included effusion of right wrist (condition in which there is an excessive build-up of fluid within the joint of the right wrist), protein calorie malnutrition (condition of nutritional status in which reduced availability of nutrients leads to changes in body composition and function), fracture of lower end of right radius (broken bone of lower right arm near the wrist), and abnormal weight loss (unintentional weight loss). Review of Resident #70's Admission MDS assessment dated [DATE] revealed she had a BIMS score of 14 out of 15 indicating she had intact cognitive function, she used a wheelchair for mobility, required set-up assistance with eating, received a regular diet and had no reported weight loss or gain and there was no documentation of mouth/dental pain or issues and no dental CAA's were triggered at the time of the assessment. Record review on 1/29/25 at 2:12 pm of facility Grievance/Complaint Form for Resident #70 completed by Social Worker and dated 12/2/24 revealed in part: Family member reports that residents' dentures are missing . and listed the date incident occurred as 11/26/24. Recommendations/Corrective Action taken: Resident was placed on dental list to be fitted for new dentures . Record review on 1/29/25 at 2:15pm of facility undated dental Appointment Pull Chart List revealed: Resident #70 had a dental appointment on 2/14/25 at 2:00 pm. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Telephone interview followed immediately by an in-person interview with family member of Resident #70 on 1/28/25 at 2:57 pm who said that he requested Resident #70 receive a puree diet back in early December 2024 because Resident #70 could not eat her regular diet without her upper denture which was lost back on 11/26/24. Family member said they spoke with the SW repeatedly immediately after the loss of the upper denture on 11/26/24 and was told that the facility assumed no responsibility for the loss of the dentures and would not pay to replace them. Family member said that he offered to split the cost of dentures 50%/50% with the facility but SW told him Administrator said no. Family member said they never spoke with Administrator or DON. The Family member said they only spoke with the SW and the SW said that Resident #70 needed a payor source to see the dentist. The Family member said that Resident #70 and had just gotten approved for Medicaid in January 2025. The family member said that after about 10 days to two weeks after Resident #70's upper dentures were lost, and Resident #70 still had not seen the dentist and when he asked the SW about this, he had repeatedly been given excuses about the holidays and the winter storm for why Resident #70 had not been seen by the dentist yet. Interview on 1/28/25 at 4:08pm with Administrator who said that SW managed scheduling of dental consultations for residents and was responsible for the facility's dental program. The Administrator said he was advised by corporate oversight that they would not pay for dentures. The Administrator said he was not informed of family member's offer to split costs 50%/50%. The Administrator said that he did not know when Resident #70 was supposed to see the dentist for the first time. The Administrator said he thought the grievance had been resolved and that the SW was also responsible for the grievance follow ups. The Administrator did not respond when asked if he thought waiting from 11/26/24 until 2/14/25 to see a dentist was too long to wait. The Administrator said he was brand new and had only worked at the facility for few months. Interview with the SW on 1/28/25 at 4:24pm he said he was responsible for sending referrals and for scheduling dental services for the facility residents. When asked if he had updated Resident #70 or her family member on the first dental visit being scheduled for 2/14/25, the SW said that he spoke with Resident #70's family member almost every day but could not recall if he told them that the first dental appointment was not until 2/14/25. When asked if he thought waiting from 11/26/24 until 2/14/25 to be seen by a dentist for new dentures was too long of a wait, the SW replied 12/2/24. The SW said that the grievance was on 12/2/24. The SW then said that he initiated the referral process on 12/10/24 and would look to see how he could provide documentation as he could not show surveyor in the facility's EMR or Resident #70's clinical notes, where his documentation of the referral with dental services and communications with Resident #70 or her family members could be located in Resident #70's clinical record. When asked if he had informed the DON and Administrator about any potential delays in Resident #70 being seen by a dentist, the SW huffed and said that he thought he had discussed the situation with everyone and moving forward he would document everything as it happened. Interview on 1/29/25 with RD at 12:29 pm she said that Resident #70 had not triggered for weight loss despite not having her upper dentures, until January 2025. RD said that Resident #70 did not have significant weight loss and that she evaluated all facility residents upon admission and quarterly and as needed when clinically indicated. RD said that Resident #70 admitted to facility with history of significant weight loss but had not had a significant weight loss since admission. RD said that last month in December, it was brought to her attention that Resident #70 was having trouble chewing without her upper denture and the family member requested a pureed diet. RD said IDT and physician agreed with recommendation. RD said she had no updates on Resident #70's denture or dental visit status. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation with on 1/30/25 at 8:15 am observed staff removing breakfast trays from hallway and observation of Resident #70's breakfast tray revealed she had consumed all of hot cereal on tray for a meal intake of 25%,. 100% of coffee and health shake were consumed. The DON proceeded to bedside with surveyor and had Corporate Clinical Nurse on telephone at the time of the observation and interview. Resident #70 who was seated in bed appropriately groomed and dressed. Resident #70 said she did not have any issue with eating soft foods now but said that if she had her dentures, she would eat regular food. Resident #70 said that she had no pain in her mouth. Resident #70 said that she did not know when she was supposed to see the dentist because her family member kept track of all of those things for her. Resident #70 said she wished she had her teeth but did not feel neglected over not having them because she can eat other things and was not a big eater anyway . Resident #70 said she did not know how long it had been since she lost her teeth and said she did not feel like it was taking too long to get new ones. Resident #70 shrugged her shoulders and stated, what's time in a place like this. Resident #70 said she was [AGE] years old and content for now. Interview on 1/30/25 with DON at 09:00am she said she and her ADON were responsible for monitoring weights at the facility and that Resident #70 had no significant weight loss since the loss of her dentures. The DON said that the SW was responsible for ensuring residents were added to the dental list and that she was not aware of any significant delay in Resident #70 getting a dental referral and actual appointment with the dentist. The DON said that she did not believe Resident #70 had been neglected by having to eat a pureed diet due to not having her upper dentures and said that at one point Resident #70 had a referral to go home with family member on hospice. The DON said that she had not been updated on actual date of Resident #70's first dental appointment. The DON did not respond when asked if she thought waiting from November until February to see a dentist was too long. Telephone interview on 1/30/25 at 11:10 am with MDD A who said that Resident #70 was [AGE] years old and had no bone for her upper denture to fit properly and comfortable. MDD A said that bone loss was a part of the aging process and that most likely once Resident #70 received the new upper dentures, they will not fit her well or be comfortable and Resident #70 will most likely end up not wearing them. MDD A said that waiting from late November until mid-February to be seen by a dentist would not have a negative clinical impact on Resident #70 . Record review on 1/30/25 at 2:33pm of SW text message log revealed he placed calls and text messages to Dental Company A starting on 12/11/24. Requested dental policy and procedure from DON on 1/30/25 at 09:00am and Administrator on 1/30/25 at 11:13 am. At time of survey exit on 1/30/25 at 5:00pm, no policy had been provided to the survey team for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675848	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Webster	17231 Mill Forest Webster, TX 77598

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036 Based on observation, interview and record review, the facility failed to maintain medical records on each resident that are accurately documented for 1 (Resident #3) of 5 residents reviewed for resident records. Resident #3's Medication Administration Record showed that Mucinex DM oral tablet extended release 12 Hour 30-600 mg was documented as being given when guaifenesin 400 mg tablet was administered. The failure could place residents who receive medications from facility staff at risk for less than therapeutic benefits, and/or not receiving ordered medications due to inaccurate documentation of administration. Findings include: Record Review of Resident 3's face sheet dated 1/30/25 revealed resident was a [AGE] year old male admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke), Dysphagia (difficulty swallowing), Type 2 Diabetes Mellitus, Hypertensive Disease with Heart Failure with history of acute upper respiratory infection and acute bronchitis. Record review of Resident's 3's quarterly MDS dated [DATE] revealed a BIMS score of 15 that suggests Resident #3's cognition is intact. Record review of Resident 3's January Medication Administration Record printed on 1/30/25 revealed Mucinex DM Oral Tablet Extended Release 12 Hour 30-600 mg (Dextromethorphan-Guaifenesin) Give 1 tablet by mouth every 12 hours for Cough and congestion for 7 days with a start date of 1/22/25 at 9 a.m. and discontinue date of 1/28/25 at 4:57 p.m. Mucinex DM was documented as being administered from 1/22-1/27/25 at 9 a.m. and 9 p.m. and on 1/28/25 at 9 a.m. Record review of Resident 3's Care Plan provided on 1/30/25 revealed a focus that Resident 3 is at risk for frequent infections related to diabetes mellitus with goal that Resident 3 will have no complications related to diabetes through the review date. Observation of Resident 3's medication administration on 1/28/25 at 8:23 a.m. revealed that Resident 3 was administered guaifenesin 400 mg for order of Mucinex DM Oral Tablet Extended Release 12 Hour 30-600 mg (Dextromethorphan-Guaifenesin) Give 1 tablet by mouth every 12 hours by CMA A. Observation of 100 hallway medication cart on 1/28/25 at 4:55 p.m. with CMA A revealed that no Mucinex DM could be found with either the over the counter medications or with Resident #3's medications from the pharmacy. (continued on next page)

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	675848	A. Building B. Wing	01/30/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview of CMA A on 1/28/25 at 12:54 p.m. revealed that she notified the charge nurse (LVN B) about three days prior to interview when she could not find the Mucinex DM order and was instructed that she could give the guaifenesin 400 mg. CMA A said that the Mucinex was on order. CMA A said that Resident #3 was previously taking guaifenesin 400 mg and the order was recently changed to Mucinex DM . CMA A said that she normally works on the hall that Resident #3 is currently residing on which shows that CMA A is familiar with Resident #3 and gives his medications frequently. Interview of LVN B on 1/28/25 at 1:02 p.m. revealed that she was not aware that Resident #3 was receiving guaifenesin 400 mg instead of Mucinex DM. LVN B said that Resident #3 had been taking guaifenesin 400 mg for years and it was changed to Mucinex DM for seven days last week when resident got sick. Interview of CMA A on 1/28/25 at 4:47 p.m. revealed that she did not document in the facility's electronic medical record when she notified the nurse regarding needing Mucinex DM for Resident #3. CMA A stated that she does not chart notifications to the nurse in the electronic medical record. CMA A stated she has given Resident #3 guaifenesin 400 mg since she started working at the facility. Interview of LVN C on 1/29/25 at 11:22 a.m. revealed she could not remember administering specific medication to Resident #3 but was not aware of him missing any medications. Per Resident 3's January MAR, LVN C had documented administering Mucinex DM at 9 p.m. 1/23/25, 1/24/25 and 1/25/25. Interview of CMA B on 1/29/25 at 11:45 a.m. revealed that she would have administered medications to Resident #3 as what is documented on Resident 3's medication administration record. Per Resident 3's January MAR, CMA B had documented administering Mucinex DM at 9 a.m. on 1/25/25 and 1/26/25. Record review of facility's policy General Guidelines for Medication Administration revealed that medications are to be administered as prescribed in accordance with good nursing principles and practices. Record review of facility's policy Administration Procedures for All Medications revealed that after administration of a medication that staff should document administration in the MAR or TAR.