STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675856	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitesboro Health and Rehabilitation Center	1204 Sherman Dr Whitesboro, TX 76273

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49459 Based on observations, interviews, and record review the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of four residents reviewed for accidents and supervision. The facility failed to transport the resident in a safe manner by using the rollator walker as a wheelchair resulting in the resident falling forward and sustaining fractures to her left elbow, and right hip. A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator and DON on 03/20/2025 at 3:45 PM. The noncompliance began on 02/15/2025 and ended on 02/21/2025. The facility corrected the noncompliance before the investigation began. This failure could place residents at risk of injury and a decreased quality of life. Findings Included: Record review of Resident # 2's Face Sheet printed 03/18/25 reflected was an [AGE] year-old female admitted to the facility on [DATE]. It reflected a history of falls with injury; Rheumatoid Arthritis, history of prior fractures, advanced osteoarthritis, lack of coordination, muscle weakness, a BIMS score of 15 , (brief screening tool that aids in detecting cognitive impairment) , however, the resident was noted to have difficulty focusing and disorganized thinking at baseline. Record review of Resident #2's Care Plan dated 03/18/25 revealed: The resident has an ADL Self Care Performance Deficit Date Initiated: 12/16/2024 - Interventions. The resident uses a walker Date Initiated: 12/16/2024. Toilet use: requires staff x1 for assistance Date Initiated: 12/16/2024. Walking: requires staff x1 for assistance Date Initiated: 12/16/2024 (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of nursing notes dated 02/15/2025 at 1:30 PM Resident #2 complained of pain to her left shoulder, right elbow, and hip after falling from her rollator walker used for transporting her to the restroom by LVN C. She was medicated for pain but did not have relief from this, so she was sent to ER for evaluation. She returned same day with diagnosis of non-displaced hairline fracture to left proximal humorous and periprosthetic fracture around right internal prosthetic right hip joint. Further record review dated 02/15/25 at 5:14 PM, during the investigation of the incident, it was discovered that LVN C was transporting the resident using the rollator walker. The resident attempted to adjust herself in the seat of the walker while it was in motion and fell forward. As a result, the resident sustained a fracture to her left humorous and to her right femur. During an interview on 03/19/25 at 5:10 PM, LVN C, she stated she had been a nurse for about [AGE] years. She stated she was the weekend supervisor and sometimes on the weekends she would help the CNA. She stated sometimes the rollator and wheelchair were in resident #2's room. On 02/15/25, she stated she asked the resident which device she wanted to use to be transported, and the resident stated she wanted the rollator. LVN C stated she knew the resident should have been transported in the wheelchair and she had transferred Resident #2 using the rollator before. She said she helped the resident up and sat her in the rollator seat, moved forward then stopped for a second and the resident just rolled out and on the floor. LVN C stated she called and asked for assistance and then made the immediate decision to send her to the hospital for evaluation because resident #2 had some fractures in the past. LVN C stated if she had known Resident #2 was weaker, she would have sat her in the wheelchair. She said I have been in nursing homes for years; I usually have a second person with me but this time I did not. LVN C stated she had received one on one training after the incident and was also part of the group in service training on resident transfers, abuse, or neglect after the incident, and they also specified on not to use the Rollator, and ANE. Resident #1 was no longer at the facility and could not be contacted for interview. Record review of hospital records dated 02/15/25 revealed x-rays completed with diagnosis of fracture of Resident #1's right femur (thigh bone) and left humorous (upper arm bone). Record review of Care Plan dated 03/17/25, Resident #2 Interventions initiated prior to surveyor entry on 03/18/25: RP notified 02/15/25. MD notified 02/15/25. Record review of Investigation Safe surveys for observations of staff using rollator for transporting residents 02/15/25 LVN C, was suspended pending investigation. 02/15/25 02/21/25 One on one in service with LVN C over Transferring with a rollator walker specifying intended use and prohibiting using rollator as a wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Low bed ordered for resident. Pain management for fracture and bruising The facility completed in- services of all staff 23 total, on 02/17/25 on preventive strategies to reduce falls, falls/ ambulation difficulty, change in condition. Record review of Resident #2's In-services: dated 02/17/25, title Transferring with a rollator walker specifying intended use prohibiting using rollator as a wheelchair. Abuse and Neglect Monitoring - DON/designee to ask 6 nursing staff members per week how to locate how much assistance is needed for a resident task and what they would do if the proper number of staff is not present, resident. During facility rounds, are there any signs of staff performing their duties in a neglectful manner? Note any corrective actions. DON / Designee to monitor at least 5 of the following processes each week to ensure the proper number of staff is providing assistance: bathing, bed mobility, transferring, walking, incontinent care. Record review of Resident # 1's Care plan updated 02/15/25: The resident has an ADL Self Care Performance Deficit Date Initiated: 12/16/2024. Revision on: 03/17/2025 Toilet use: requires staff x1 for assistance Date Initiated: 12/16/2024. Created by: CN The resident uses a walker Date Initiated: 12/16/2024. Created by CN Record review of Resident # 1 Interventions: TRANSFER: the resident requires Mechanical lift and 2 staff for transfers. Date Initiated: 02/15/2025. Created by: RGCN The resident has a left humerus fracture and right femur fracture post Fall Date Initiated: 02/16/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Revision on: 03/17/2025 The resident has a left humerus fracture and right femur fracture post fall. Date Initiated: 02/16/2025. Revision on: 03/17/2025 GOAL: The resident will remain free of complications related to hip fracture, such as contracture formation, embolism, and immobility through review date Interventions: Rollator taken home by family Date Initiated: 02/17/2025 Created by:RGCN Report any pain to the charge nurse Date Initiated: 02/16/2025. Created by: RGCN Reposition as necessary to prevent skin breakdown. Prevent 90-degree flexion to prevent circulation problems. Date Initiated: 02/16/2025. Created by: RGCN The resident is risk for falls. Had an actual fall Date Initiated: 12/16/2024. Revision on: 03/17/2025 Goal The resident will be free of falls through the review date. Date Initiated: 12/16/2024. Intervention Ensure that the Resident is wearing appropriate footwear when ambulating or mobilizing in w/c. Date Initiated: 12/16/2024. Created by: CN. Anticipate and meet the resident's needs. Date Initiated: 12/16/2024. Created by: CN. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of NN dated 02/18/25 revealed the resident had a follow up appointment with orthopedic MD for 03/03/25 and remained on NWB status until then was upgraded to WB as tolerated. Sling to affected arm and PT. During an interview on 03/19/25 at 2:51 PM CNA A, stated she has been a CNA for [AGE] years at this facility. CNA A stated she has never transported a resident in a rollator walker. CNA A stated the correct method to transport residents, is If they can walk with a gait belt, or a wheelchair, if it is a rollator you must walk with them but since we have been in-serviced, we do not use it. CNA A stated she had heard about the incident nut was not involved. She stated it was on another wing. She verified that she had been in serviced over using rollator and that management staff were checking on them. During an interview on 03/19/25 at 3:07 PM CNA B stated she has been a CNA for [AGE] years, 6 months at this facility. She stated she had never transported a resident in a rollator walker. She stated walkers are made for walking that is what their purpose is. She stated the correct method to transport residents depending on their care plan, was to use a gait belt. Verbally let them know step by step, she said it helped them when you are communicating with them. She stated she had heard about the incident and was inservice over transporting residents, falls and walkers and wheelchairs. During an interview on 03/19/25 at 3:33 PM CNA C stated has been a CNA for [AGE] years, has been here at this facility for about 2 months. She stated she had never transported a resident in a rollator walker and that it is to be used as walker. She stated the correct method for using a walker was a walker make sure they use it properly, use a gait belt to transfer them. She was not familiar with the incident abd had received in-servicing on how to properly use a wheelchair, and do not use a Rollator. She stated that the person transporting the resident should ensure they are performing the task correctly. During an interview on 03/19/25 at 2:15 PM, OTA stated she has never transported a resident in a rollator walker. OTA stated the correct method to transport residents is by using a wheelchair or if resident is able to ambulate with walker and gait belt. OTA stated she heard was a CNA was pushing a resident in a in a rollator, and she fell hit her face on the floor. OTA stated we were in serviced it mainly dealt with the rollator is not a mode of transport and trained on the use of wheelchairs. Interview attempts with PT D on 03/19/25 at 2:36 PM, and 2:45 PM were unsuccessful left VM. During an interview on 03/19/25 at 2:55 PM, PTA E, stated works part time more like as a needed basis. Stated the following, she had never transported a resident in a rollator walker. She stated it was not the correct method to transport residents, it was by wheelchair, and should not t use the Rollator PTA E was not familiar with the incident and confirmed in-servicing was received after the incident over how to transport residents, and not to use the rollator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/19/25 at 2:45 PM with PTA F, stated has been a here since 10/2024. PTA F stated he has never transported a resident in a rollator walker. PTA F verbalized correct method of transporting residents. He stated he was not familiar with the incident. On 03/19/25 at 3:45 PM, a request was submitted to the ADMIN requesting the following policies from the facility. Assisting residents with toileting, transfers or transportation of residents, and a safe handling policy. The ADMIN stated they had no specific safe patient handling policy. During an interview on 03/19/25 at 4:20 PM with LVN F, stated she has been an RN for approximately [AGE] years. LVN F had stated she never has transported a resident in a rollator walker. LVN F, stated the correct method to transport residents, was either by walker or wheelchair depending by their ambulation status. LVN F, stated she knew about the incident, she completed the fall assessment on Resident #2. She stated in servicing was done over no transportation on the seated walkers. Use wheelchairs. During an interview on 03/19/25 at 4:30 PM ADON, she stated had been nurse for 6 years, ADON for about 3 weeks, she stated she had been trained on resident transfers. She stated she was trained in this facility. The ADON, stated the resident should not have been transported in the walker and should have been transported to the restroom with the use of a wheelchair. The ADON stated after the incident the entire staff received in service on resident transfers, abuse, or neglect. Additionally, on to not use a rollator as a means of transport, use a wheelchair. During an interview on 03/19/25 at 5:30 PM, RCN stated she has been trained in the proper technique on resident transfers. RCN stated as part of her regularly assigned duties it is her job to instruct medical staff, including nurses on the proper techniques to transfer residents. RCN stated she should not have used the seated walker to transport the resident seated walker. But instead used a wheelchair, to transport the resident to the restroom. RCN stated she was the one responsible for and provided everyone on the nursing staff on proper transfer techniques including that a wheelchair is the proper method and not to use a rollator as a transport device because the resident could fall out of the rollator and be injured. During an interview on 03/20/25 at 9:00 AM, the ADMIN stated she has been trained by the Therapy department on resident transfers, RGCN, RELIAS training. ADMIN stated the LVN should not have transported the resident in the walker, but with a wheelchair if it was not a mobile resident. ADMIN stated after the incident all staff received in service on resident transfers, abuse, or neglect. During record review of staff training on 03/20/25 at 8:15 AM. Certifications were validated and verified via documentation provided from the facility, regarding the training on resident transfers. During record review of LVN C's employee file on 03/20/25 at 8:30 it indicated no previous infractions. Her file was reviewed and reflected that she received in service on transfer/transportation of residents during one-on-one training following the incident as well as in a group setting from 02/16/25 to 02/17/25. Observation of resident transfers on 03/20/25 from 1:00 PM to 3:00 PM for staff CNA A, CNA B, CNA C, PTA. COTA did not reflect any concerns for transfer technique. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy dated October 5, 2016, titled Fall Risk Mini Manual 2003. After risk is assessed, individualized nursing care plans will be implemented to prevent falls. The resident and/or family members will be educated on methods to prevent falls. Interventions will focus on manipulating the environment, educating the resident/family, implementing rehabilitation programs to improve functional ability, and care monitoring of medication side effects. Interventions initiated prior to surveyor entry on 03/18/25: Audit of all residents requiring use oof assistive devices including rollator walkers Notification of MD and RP on 02/15/25 One on one in service with LVN C Self-report to HHSC on In-services: * Transferring with a rollator walker specifying intended use prohibiting using rollator as a wheelchair. * Abuse and Neglect Monitoring of all above in-services by DON - from 02/16/25 to 03/14/25 A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator and DON on 03/20/2025 at 3:45 PM. The noncompliance began on 02/15/2025 and ended on 02/21/2025. The facility corrected the noncompliance before the investigation began.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 49459 Based on observations, interviews, and record reviews, the facility failed to provide pharmaceutical services (including procedure that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 (Resident #1) of four residents reviewed for pharmaceutical services. A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator and DON on 03/20/2025 at 3:45 PM. The noncompliance began on 01/25/2025 and ended on 01/28/2025. The facility corrected the noncompliance before the investigation began. The facility failed to administer Resident #1's Lacosamide (anti- seizure medication) according to medication administration orders. Resident #1 did not receive her antiepileptic medication for two days (01/25/25 and 01/26/25). This failure could place residents at risk of not receiving medications as ordered by the physician, increasing the risk of inducing life-threatening seizures, injury and not receiving the therapeutic benefits of the medications. Findings included: Record review of Resident #1 face sheet dated 03/18/25, revealed Resident #1 was a [AGE] year-old female admitted to the facility for respite services on 01/21/25 and readmitted to the facility on [DATE]. Diagnosis included Metabolic Encephalopathy (chemical imbalance caused by illness in the blood affecting the brain); Epilepsy without status Epilepticus (seizure without a seizure lasting more than 5 minutes) and Severe Intellectual disability. Record review of Resident #1's MDS assessment, dated 01/24/25, revealed the resident's BIMS score of 03, which indicated severe cognitive impairment. Record review of Resident #1's medication administration record, dated from 01/21/25 to 01/31/25 revealed Resident #1 was receiving Lacosamide Oral Tablet 200 MG (Lacosamide) Give 1 tablet by mouth two times a day for Seizures. Review of Resident #1's physician order dated 01/21/25, on 03/19/25 revealed, Lacosamide (anti-convulsant that works by decreasing abnormal electrical activity in the brain) oral tablet 200 mg (Lacosamide) give one tablet by mouth two times a day for seizures. Review of MAR (Medication Administration Record) dated [DATE] on 03/19/25, revealed Resident #1's Lacosamide 200 mg tablet had been documented as having been administered twice a day from 01/21/25 to 01/27/25. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Individual Resident Narcotic Record for resident # 1 initiated on 01/23/25 revealed that the facility did not administer the Lacosamide as ordered. There was an overage of Lacosamide remaining on the narcotic count after Resident #1 was sent to the hospital for her seizures. Resident # 1 missed four doses of her Lacosamide in total. On 03/19/25, review of the SBAR document dated 01/27/25 revealed, that LVN F had notified MD that Resident #1 had experienced three separate seizures lasting 45 seconds, 45 seconds and 1 minute 30 seconds respectively. Resident was sent to the hospital for evaluation. She returned the same day with no new orders. During an interview on 03/19/25 at 4:50 PM LVN A stated he worked weekends, rotating 12-hour shifts. He advised it was mid-week and not his normal shift on the date of the incident on 01/25/25. LVN A said when Resident #1 was admitted to the facility on [DATE], she did not have any medication available at the facility. He stated he called the pharmacy to request the medications. The medications were received on 01/22/25. The resident accidentally dislodged her IV catheter on 01/23/25 and was sent out to the hospital for replacement. She returned to the facility on [DATE] with no new medication orders. LVN A stated he looked for the Lacosamide on 01/25/25 for administration and he was unable to locate it. He stated he looked in the E kit and the Lacosamide was not there. He stated when he could not find the medication, he called the pharmacy to request it but did not call the DON to let her know. He said the meds were found in the cart on 01/27/25 but was not in the usual order, as they were normally organized alphabetically. LVN A stated he did not recall it being it being in alphabetical order so he could not find it. LVN A stated he did not administer Lacosamide 200 mg oral tablet on 01/25/25 and 01/26/25 because he thought the medication was unavailable. LVN A was given one on one in-service over medication administration by the DON on 01/27/25. LVN A stated it was both his and LVN B's responsibilities to administer medications to the residents. LVN A resigned on 01/27/25. During an interview on 03/18/25 at 5:30 PM, LVN B said she has been a charge nurse for about 4 months here and have been a nurse for [AGE] years. LVN B stated they did not have Lacosamide. Everything else came in but that one. She stated Resident #1 did not have any seizures for the whole shift. She stated the meds came in the next day or the day after and that the E kit did not have the Lacosamide. The meds were not administered on 01/25/25 and 01/26/25. LVN A said failure to administer medication could place the resident at risk and jeopardize their health and safety. LVN A called first on 01/25/25 to make sure it was coming he was told it would be there that night. She stated they usually get them by around 830 -900 PM at the latest, and they do not get deliveries over the weekend. LVN B said, we can't give any meds if we do not have the medication. LVN B stated we did not have Lacosamide 200 mg, everything else came in but that one. She said the e-kit medication is placed in the box by the resident's name and the lock box is where narcotics are stored, it is in alphabetical order. LVN B stated she did not recall Resident #1 having any seizures on the shifts that she worked. The medication did not come in until 01/27/25. LVN B stated she did not think that not receiving the medication would have had a negative effect on Resident #1's care and well-being due to her age. LVN B stated Resident #1 was discharged to the hospital for seizures on 01/27/25. LVN B received in-service with group over 5 Right of medication administration on 01/28/25. Further record review dated 01/28/25, medication administration record indicated the medication was administered to Resident #1. Review of the Narcotic count sheet revealed no Lacosamide was administered on 01/25/25 and 01/26/25. LVN A and LVN B documented the medication administration incorrectly and were suspended pending investigation. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a follow up interview on 03/20/25 at 2:55 PM LVN D stated they were in serviced on what to do when medications are not available. It comprised of Check to see if available in e-kit. If not in e-kit call MD to notify of medication unavailable. Request alternative available in-house medication and a HOLD order for current medication. Call pharmacy, request refill medication to be sent out. If replacement order, ask for that medications to be sent out. Correct orders in PCC either HOLD order or replacement. Chart your conversations and resolution. Ensure to put names of parties notified- RP, MD, and Pharmacy. Notify DON of above action. LVN D stated received in service training for location and using of e-kit. LVN D was able to correctly verbalize all current procedures related to medications. During a follow up interview on 03/20/25 at 3:00 PM LVN E advised it can have a negative impact on residents if they do not receive their anti-seizure meds, because it would put them at risk for break through seizures. She advised that if they do not receive their anti-seizure meds, they can have breakthrough seizures. LVN F stated they were in serviced on what to do when medications are not available. It comprised of Check to see if available in e-kit. If not in e-kit call MD to notify of medication unavailable. Request alternative available in-house medication and a HOLD order for current medication. Call pharmacy, request refill medication to be sent out. If replacement order, ask for that medications to be sent out. Correct orders in PCC either HOLD order or replacement. Chart your conversations and resolution. Ensure to put names of parties notified- RP, MD, and Pharmacy. Notify DON of above action. LVN E stated received in service training for location and using of e-kit. LVN E also correctly verbalized knowledge of medication procedures. During a follow up interview on 03/20/25 at 3:10 PM with LVN F advised that if they do not receive their anti-seizure meds, they can have breakthrough seizures. LVN F stated they were in serviced on what to do when medications are not available. It comprised of Check to see if available in e-kit. If not in e-kit call MD to notify of medication unavailable. Request alternative available in-house medication and a HOLD order for current medication. Call pharmacy, request refill medication to be sent out. If replacement order, ask for that medications to be sent out. Correct orders in PCC either HOLD order or replacement. Chart your conversations and resolution. Ensure to put names of parties notified- RP, MD, and Pharmacy. Notify DON of above action. LVN F stated received in service training for location and using of e-kit and was able to correctly identify medication procedures. Attempted phone call to Resident #1 Representative, on 03/19/25 at 3:02 PM went unanswered and no call backs were received by time of exit. During an interview on 03/19/2025 at 5:24 PM with Physician, he stated he was familiar with the incident for Resident # 1. He stated the facility notified him about the missed medications, and she had missed them. He stated the possible outcomes of missing medications for this resident specifically was inducing a seizure if her medication levels drop. He stated it would be concerning if a resident did not receive their doses of Lacosamide because it would put them at risk for break through seizures. He stated his expectations related to medication administration was discussed at the QAPI meeting and was care planned. He said that there had been no other additional missed medications of which he was aware. He stated an ADHOC QAPI meeting was completed on 01/27/25 to include the IDT team and Medical Director during which this incident was the main topic. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675856	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitesboro Health and Rehabilitation Center	1204 Sherman Dr Whitesboro, TX 76273

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled Pharmacy Policy & Procedure Manual 2003, stated that The Accountability Audit of Controlled Drug Audit Sheets record will be filled in with the information that corresponds to the Rx supply. Staff will note how many doses were given and how many doses remain. 15. Medication errors and adverse drug reactions are immediately reported to the resident's Physician. In addition, the Director of nurses and/or designee should be notified of any medication errors. Any medication error will require a medication error report that includes the error and actions to prevent reoccurrence. Record review of the facility PIR on 03/18/24 revealed that the facility completed their investigation the incident. Th investigation included the audit of all medication, including anti-seizure medication for all residents. they also conducted audits of narcotic sheet documentation during which it was discovered that LVN A and LVN B did not administer Resident #1s Lacosamide as prescribed. The facility suspended LVN A and LVN B and completed their investigation. Resident #1 did return to the facility on [DATE], but discharge on the same day back to her previous residence per her family's request. The facility initiated the following interventions prior to surveyor entry on 03/18/25. 100% audit of all medications ordered in facility. 100% audit of all anti-epileptic medications for all residents The facility obtained all medications as ordered for Resident #2 Medication Error report completed 01/27/25. Notification of MD and RP 01/27/25 LVN A and LVN B were suspended pending investigation. Self-report called in to HHSC on In serviced all staff completed on 01/27/25 over: Admission and readmission medication reconciliation o Use of E-kit, when and how to use o medication administration, including seizure medication and those requiring triplicate o Physician orders o What to do if medication is unavailable o Abuse, Neglect, and Exploitation o Change in condition. (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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator and DON on 03/20/2025 at 3:45 PM. The noncompliance began on 01/25/2025 and ended on 01/28/2025. The facility corrected the noncompliance before the investigation began.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49459 Based on observations, interviews, and record reviews, the facility failed to ensure that residents are free from any significant medication error for 1 (Resident#1) of 4 residents reviewed for medication errors. A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator and DON on 03/20/2025 at 3:45 PM. The noncompliance began on 01/25/2025 and ended on 01/28/2025. The facility corrected the noncompliance before the investigation began. The facility failed to administer Resident #1's Lacosamide (anti- seizure medication) according to medication administration orders. Resident #1 did not receive her antiepileptic medication for two days (01/25/25 and 01/26/25). This failure could place residents at risk of not receiving medications as ordered by the physician, increasing the risk of inducing life-threatening seizures, injury and not receiving the therapeutic benefits of the medications. Findings included: Record review of Resident #1 face sheet dated 03/18/25, revealed Resident #1 was a [AGE] year-old female admitted to the facility for respite services on 01/21/25 and readmitted to the facility on [DATE]. Diagnosis included Metabolic Encephalopathy (chemical imbalance caused by illness in the blood affecting the brain); Epilepsy without status Epilepticus (seizure without a seizure lasting more than 5 minutes) and Severe Intellectual disability. Record review of Resident #1's MDS assessment, dated 01/24/25, revealed the resident's BIMS score of 03, which indicated severe cognitive impairment. Record review of Resident #1's medication administration record, dated from 01/21/25 to 01/31/25 revealed Resident #1 was receiving Lacosamide Oral Tablet 200 MG (Lacosamide) Give 1 tablet by mouth two times a day for Seizures. Review of Resident #1's physician order dated 01/21/25, on 03/19/25 revealed, Lacosamide (anti-convulsant that works by decreasing abnormal electrical activity in the brain) oral tablet 200 mg (Lacosamide) give one tablet by mouth two times a day for seizures. Review of MAR (Medication Administration Record) dated [DATE] on 03/19/25, revealed Resident #1's Lacosamide 200 mg tablet had been documented as having been administered twice a day from 01/21/25 to 01/27/25. Review of the Individual Resident Narcotic Record for resident # 1 initiated on 01/23/25 revealed that the facility did not administer the Lacosamide as ordered. There was an overage of Lacosamide remaining on the narcotic count after Resident #1 was sent to the hospital for her seizures. Resident # 1 missed four doses of her Lacosamide in total. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/19/25, review of the SBAR document dated 01/27/25 revealed, that LVN F had notified MD that Resident #1 had experienced three separate seizures lasting 45 seconds, 45 seconds and 1 minute 30 seconds respectively. Resident was sent to the hospital for evaluation. She returned the same day with no new orders. During an interview on 03/19/25 at 4:50 PM LVN A stated he worked weekends, rotating 12-hour shifts. He advised it was mid-week and not his normal shift on the date of the incident on 01/25/25. LVN A said when Resident #1 was admitted to the facility on [DATE], she did not have any medication available at the facility. He stated he called the pharmacy to request the medications. The medications were received on 01/22/25. The resident accidentally dislodged her IV catheter on 01/23/25 and was sent out to the hospital for replacement. She returned to the facility on [DATE] with no new medication orders. LVN A stated he looked for the Lacosamide on 01/25/25 for administration and he was unable to locate it. He stated he looked in the E kit and the Lacosamide was not there. He stated when he could not find the medication, he called the pharmacy to request it but did not call the DON to let her know. He said the meds were found in the narcotic box on 01/27/25 so he could not find it originally. LVN A stated he did not administer Lacosamide 200 mg oral tablet on 01/25/25 and 01/26/25 because he thought the medication was unavailable. LVN A was given one on one in-service over medication administration by the DON on 01/27/25. LVN A stated it was both his and LVN B's responsibilities to administer medications to the residents. LVN A resigned on 01/27/25. During an interview on 03/18/25 at 5:30 PM, LVN B said she has been a charge nurse for about 4 months here and have been a nurse for [AGE] years. LVN B stated they did not have Lacosamide. Everything else came in but that one. She stated Resident #1 did not have any seizures for the whole shift. She stated the meds came in the next day or the day after and that the E kit did not have the Lacosamide. The meds were not administered on 01/25/25 and 01/26/25. LVN A said failure to administer medication could place the resident at risk and jeopardize their health and safety. LVN A called first on 01/25/25 to make sure it was coming he was told it would be there that night. She stated they usually get them by around 830 -900 PM at the latest, and they do not get deliveries over the weekend. LVN B said, we can't give any meds if we do not have the medication. LVN B stated we did not have Lacosamide 200 mg, everything else came in but that one. She said the e-kit medication is placed in the box by the resident's name and the lock box is where narcotics are stored, it is in alphabetical order. LVN B stated she did not recall Resident #1 having any seizures on the shifts that she worked. The medication did not come in until 01/27/25. LVN B stated she did not think that not receiving the medication would have had a negative effect on Resident #1's care and well-being due to her age. LVN B stated Resident #1 was discharged to the hospital for seizures on 01/27/25. LVN B received in-service with group over 5 Right of medication administration on 01/28/25. Further record review dated 01/28/25, medication administration record indicated the medication was administered to Resident #1. Review of the Narcotic count sheet revealed no Lacosamide was administered on 01/25/25 and 01/26/25. LVN A and LVN B documented the medication administration incorrectly and were suspended pending investigation. During a follow up interview on 03/20/25 at 2:55 PM LVN D stated they were in serviced on what to do when medications are not available. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator and DON on 03/20/2025 at 3:45 PM. The noncompliance began on 01/25/2025 and ended on 01/28/2025. The facility corrected the noncompliance before the investigation began.