STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675904	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windflower Health Center	5500 SW 9th Ave Amarillo, TX 79106

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on interviews and record reviews the facility failed to ensure a comprehensive care plan was developed within 7 days after completion of the comprehensive assessment for 4 of 10 residents (Resident #1, Resident #3, Resident #4, and Resident #5) reviewed for care plan timing. -The facility failed to ensure the comprehensive care plan for Resident #1 was developed within 7 days after the completion of the comprehensive assessment. -The facility failed to ensure the comprehensive care plan for Resident #3 was developed within 7 days after the completion of the comprehensive assessment. -The facility failed to ensure the comprehensive care plan for Resident #4 was developed within 7 days after the completion of the comprehensive assessment. -The facility failed to ensure the comprehensive care plan for Resident #5 was developed within 7 days after the completion of the comprehensive assessment. These failures could place residents at risk of receiving care that is not person-centered and/or is inadequate to meet the needs identified during the comprehensive assessment. Findings Include: Resident #1: Record review or Resident #1's clinical record, dated 04/02/2025, revealed that Resident #1 was a [AGE] year-old female resident who was admitted to the facility on [DATE]. Resident #1 had diagnoses to include Alzheimer's disease, type 2 diabetes mellitus without complications, parkinsonism, chronic kidney disease-state 2, psychotic disorder with hallucinations due to known physiological condition. Record review of Resident #1's MDS, dated [DATE], revealed that Resident #1's BIMS score was blank which indicated Resident #1 was not interviewable. Record review of Resident #1's most recent care plan revealed a revision date of 03/20/2025. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Resident #3: Record review of Resident #3's clinical record, dated 04/02/2025 revealed Resident #3 was an [AGE] year-old male resident who was admitted to the facility on [DATE]. Resident #3 had diagnoses to include atypical atrial flutter (rapid irregular heartbeat), atherosclerotic heart disease of native coronary artery without angina pectoris (a condition where fatty deposits build up in the coronary arteries, which supply blood to the heart), generalized anxiety disorder, chronic pain syndrome. Record review of Resident #3's MDS, dated [DATE], revealed Resident #3's BIMS score was 12 out of 15, which indicated Resident #3 had moderate cognitive deficits. Record review of Resident #3's care plan revealed a revision date of 03/30/2025. Resident #4: Record review of Resident #4's clinical record, dated 04/02/2025, revealed Resident #4 was a [AGE] year-old female resident who was admitted to the facility on [DATE]. Resident #4 had diagnoses to include multiple sclerosis, chronic congestive heart failure, paroxysmal atrial fibrillation (a type of heart rhythm disorder characterized by short, intermittent episodes of irregular and rapid heartbeats originating in the upper chambers of the heart), high blood pressure, weakness, cognitive communication deficit, restless legs syndrome, chronic pain syndrome, unsteadiness on feet, anxiety disorder. Record review of Resident #4's MDS, dated [DATE], revealed Resident #4 had a BIMS score of 15 out of 15, which indicated she did not have any cognitive deficits. Record review of Resident #4's care plan revealed a revision date of 03/21/2025. Resident #5: Record review of Resident #5's clinical record, dated 04/02/2025, revealed Resident #5 was a [AGE] year-old male resident who was admitted to the facility on [DATE]. Resident #5 had diagnoses to include multiple sclerosis, right sided hemiplegia (weakness), type 2 diabetes mellitus without complications, muscle wasting and atrophy. Record review of Resident #5's MDS, dated [DATE], revealed Resident #5's BIMS score of 15 out of 15 which indicated Resident #5 has no cognitive deficits. Record review of Resident #5's care plan, revealed a revision date of 03/20/2025. During an interview on 04/02/2025 at 2:21pm the MDS LVN stated that it was her responsibility to keep the care plans updated, and floor nurses would update the care plans as needed as well. MDS LVN was asked what a possible negative outcome for not updating care plans after an MDS assessment was completed, MDS LVN stated it could lead to a resident having an event/incident happen that is not listed on the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 04/02/2025 at 2:39pm the DON stated a possible negative outcome for not having a resident's care plan updated after a new MDS assessment was completed could lead to a possible miss of a medication change or a status decline and/or change. Record review of the facility's provided policy titled, Care plans, Comprehensive Person-Centered, revised March 2022, revealed, in part the following: .2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment, .3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. .9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration for the relationship between the resident' problem areas and their causes, and relevant clinical decision making.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47854 Based on interview, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by the resident assessments and infividual plans of care considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 1 of 5 (LVN B) staff reviewed for nursing services. The facility failed to ensure that LVN B distributed and destroyed narcotic medications in accordance with professional standards and facility policy. This failure could place residents at risk for drug diversion, lack of drug efficacy, and adverse reactions. Findings include: During an interview on 04/01/2025 at 9:50am CNA A stated she saw LVN B throw narcotics into the trash can on the medication cart. CNA A stated to LVN B there was drug buster and that was how narcotics were destroyed. CNA A stated that LVN B told her (CNA A) that she (LVN B) forgot and would destroy them that way the next time. CNA A stated that the 2nd time she saw LVN B discarded a narcotic in the trash can on the medication cart, CNA A reported to the ADM. Both of these wastes of narcotics were for Resident #2. During an interview on 04/01/2025 at 11:41am DON stated the narcotic discrepancies were with Resident #2, Resident #5, and Resident #6. DON stated narcotics for Resident #2 were thrown away in the trash can on the medication cart, and the narcotic discrepancies for Resident #5 and Resident #6 were the narcotics were left in a bedside night stand drawer or on a meal tray. DON stated she performed a narcotic audit of medications at that time. DON stated she asked LVN B where the narcotics were for Resident #5 due to medication being signed out before the end of her shift. LVN B stated she had put them in Resident #5's top drawer of his night stand. DON stated there was another narcotic sheet that revealed that Resident #5 had 20 Hydrocodone in the medication card, however when the card was visualized it only had a count of 17. LVN B was asked where the pills were, she stated to the DON that she had already gave them to Resident #5. DON stated that she interviewed Resident #5 and that he had not taken them due to him not liking the medication. DON then proceeded to interview Resident #6 regarding medication being on her meal tray (lunch) and Resident #6 stated that she had not taken any medication and had not seen any medication on the tray. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a phone interview on 04/01/2025 at 3:23 pm, LVN B stated the following: I went to go and pull the meds like I normally do. One resident (Resident #2) was out of facility, and I was in the habit of pulling a Tylenol 3 and placing it in her top drawer of her night stand. This was only the 2nd time that I had done it. The only reason that it happened on Thursday was due to Resident #2 being very tearful and in pain LVN B stated a negative outcome for preparing a narcotic for a resident and then leaving the medication was we just aren't supposed to do it. That side is very heavy when it comes to med pass, and I know that we are not supposed to do it. LVN B was asked about the medication for Resident #5 and Resident #6; LVN stated that the Resident #6 would ask for the medications to be left on bedside table, since she takes her medications one at a time. LVN B did state that she did ask if the resident would take the narcotic first and then the resident could take the remainder of her medications on her own. LVN B stated Resident #5 was starting to move around more and since Resident #5 was eating, LVN B placed the medication in the top drawer of the night stand and when the DON asked her where she put it she went to go and get the medication out of the drawer and the medication was not found. LVN B stated the negative outcome of not staying with residents until medications is taken was that there was no proof that the resident took the medication. LVN B also stated that the negative outcome of placing medications in nightstand drawers it is not in our profession, and we are taught not to do that. LVN B stated was asked if this is something that you are not supposed to do then why did you do it? LVN B stated that the day was just overwhelming, I went with HR to have a drug screen, but I have nothing to hide. During an interview on 04/01/2025 at 4:14pm ADM stated LVN B would be terminated and reported to the Texas Board of Nursing. Copies of those reports were requested by investigator. During an interview on 04/02/2025 at 9:43am DON stated a possible negative outcome of a nurse not staying with a resident to watch the resident take the medication, was that resident's pain would not be addressed and resident not taking the medication and someone else taking it. DON stated the negative outcome of having an incompetent nurse would lead to the safety of residents, and the nurse not following the 5 rights of medication administration and adequate to follow up on resident to assess if the medication was effective. During an interview on 04/02/2025 at 11:36am Resident #6 stated she had never had anyone place medication on her meal tray or in any of her nightstand drawers. Resident #6 stated I just take what they give me. Record review of facility provided policy titled, Staffing, Sufficient and Competent Nursing revised August 2022, revealed the following: .Competent Staff 4. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. 5. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. 6. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** 47854 Based on interview and record review the facility failed to establish a system of record of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintatined periodically reconciled for 3 of 10 residents (Resident #2, Resident #5, and Resident #6) reviewed for pharmacy services. 1. The facility failed to prevent LVN B from misplacing narcotics for Resident #2, Resident #5, and Resident #6. 2. The facility failed to ensure Resident #2, #5, and #6's narcotics medications were accounted for: 2 out of the 3 narcotics that were missing. These failures could place residents at risk of not receiving medication therapy that would be effective for their treatment, resulting in the exacerbation of conditions and disease processes. Findings include: Resident #2: Record review of Resident #2's clinical record, dated 04/02/2025, revealed she was a [AGE] year-old female resident who was admitted to the facility on [DATE]. Resident #2 had diagnoses to include spastic diplegic cerebral palsy (a type of cerebral palsy that primarily affects the lower limbs (legs). It is characterized by increased muscle stiffness (spasticity) and difficulty with movement and coordination), acute kidney failure, abnormal posture, hypertension (high blood pressure), neuromuscular dysfunction of bladder (a condition where bladder control is impaired due to brain, spinal cord, or nerve problems, leading to difficulties in emptying or holding urine), and colon cancer. Record Review of Resident #2's MDS, dated [DATE], revealed Resident #2's BIMS score was 15 out of 15 which indicated that Resident #2 did not have any cognitive deficits. Section GG-Functional Abilities revealed Resident #2 required maximal assistance with oral hygiene toileting hygiene, shower/bath, upper body dressing, and lower body dressing. Total dependence was needed for putting on/taking off footwear. Resident #2 only needed set up assistance with eating and touch assistance with personal hygiene. Record review of Resident #2's order summary, dated 04/02/2025, revealed Resident #2 had an order for Acetaminophen-Codeine Tablet 300mg/30mg-Give 1 tablet by mouth every 6 hours as needed for severe pain. This order had a start date of 01/16/2025 and was open ended. Record review of Resident #2's care plan, dated 02/25/2025, revealed in part, the following: Focus o I have alteration in comfort related to pain (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Goal o I will not have an interruption in normal activities due to pain through the review date. Interventions o Administer medications per orders o Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Record review of Resident #2's medication administration record, dated 03/01/2025-03-31/2025 revealed that Resident #2 received her Tylenol 3 at 8:00am and 1:00pm on 03/27/2025 with the initials of LVN B recorded as the administrator of the medication. Record review of Resident #2's narcotic count sheet dated 03/21/2025-03/27/2025, revealed that LVN B dispensed 1 Tylenol 3 tablet on 03/23/2025 with an entry of dropped, another entry on 03/26/2025 of dropped, and 03/27/2025 nurse found, medication wasted. Resident #5: Record review of Resident #5's clinical record, dated 04/02/2025, revealed Resident #5 was a [AGE] year-old male resident who was admitted to the facility on [DATE]. Resident #5 had diagnoses to include multiple sclerosis (a chronic autoimmune disease where the body's immune system mistakenly attacks the protective sheath (myelin) covering nerve fibers in the brain and spinal cord), right sided hemiplegia (weakness), type 2 diabetes mellitus without complications (elevated blood sugar), muscle wasting and atrophy(muscle loss). Record review of Resident #5's most recent MDS, dated [DATE], revealed Resident #5's BIMS of 15 out of 15 which indicates that Resident #5 had no cognitive deficits. Section GG-Functional Abilities revealed Resident #5 required total assistance with toileting hygiene, shower/bath, upper body dressing, lower body dressing, and putting on/taking off footwear. Resident #5 needed set up assistance with eating and oral hygiene; and touch assistance with personal hygiene. Record review of Resident #5's order summary, dated 04/02/2025, revealed Resident #5 had an order for Hydrocodone-Tylenol Tablet 10mg/325mg-Give 1 tablet by mouth every 8 hours as needed for pain. This order has a start date of 04/10/2024 and discontinue date of 03/28/2025. Record review of Resident #5's care plan, dated 03/20/2025, revealed in part, the following: Focus o Potential alteration in comfort related to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	pain Goal o Will be as comfortable as possible Interventions o Anticipate the resident's need for pain relief and respond immediately to any o Monitor/record/report to nurse loss of appetite, refusal to eat and weight loss. o Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. o Pain assessment, administer pain medication as ordered. Record review of Resident #5's medication administration record, dated 03/01/2025-03-31/2025 revealed that Resident #5 received his Hydrocodone-Tylenol 10mg/325mg at 7:00am and 1:00pm on 03/27/2025 with the initials of LVN B recorded as the administrator of the medication. Record review of Resident #5's narcotic count sheet dated 03/23/2025-03/27/2025, revealed that LVN B dispensed 1 hydrocodone/Tylenol 10mg/325mg tablet with no time next to date and signature. Document further revealed the medication was placed in drawer/missing, next to entry. Resident #6: Record review of Resident #6's clinical record, dated 04/02/2025, revealed she was an [AGE] year-old female resident who was admitted to the facility on [DATE]. Resident #6 had diagnoses which included Alzheimer's disease with early onset, dementia, anxiety, hyperlipidemia (high cholesterol), hypertension (high blood pressure), weakness, trigger finger, left finger. Record Review of Resident #6's MDS, dated [DATE], revealed Resident #6's BIMS score was 15 out of 15 which indicated Resident #6 did not have any cognitive deficits. Section GG-Functional Abilities revealed Resident # 6 required set-up assistance with oral hygiene toileting hygiene, shower/bath, putting on/taking off footwear, and personal hygiene. Moderate/partial assistance was needed for dressing both upper and bottom body. Record review of Resident #6's order summary, dated 04/02/2025, revealed Resident #6 had an order for Hydrocodone-Acetaminophen 10-325mg tablet-Give 1 tablet by mouth every 4 hours as needed for pain. Give 1 tab by mouth, while awake do not exceed 3 grams in 24 hours. This order has a start date of 01/07/2023 and was open ended. Record review of Resident #6's care plan, dated 03/14/2025, revealed in part, the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Focus o I have chronic joint pain Goal o I will verbalize comfort with current pain regime through the review period. Interventions o Administer Norco (hydrocodone-Acetaminophen), Tylenol as ordered. Monitor for side effects/adverse reactions and effectiveness. Report to MD PRN. o Monitor/record/report to Nurse any s/sx of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). o Provide diversional activities as accepted by [Resident #6]. Record review of Resident #6's medication administration record, dated 03/01/2025-03/31/2025 revealed Resident #6 received her Norco at 8:00am and 12:00pm on 03/27/2025 with the initials of LVN B recorded as the administrator of the medication. Record review of Resident #6's narcotic count sheet dated 03/27/2025-03/29/2025, revealed that LVN B dispensed 1 hydrocodone 10mg-325mg tablet with entry for 4:00pm dose missing. During an interview on 04/01/2025 at 8:56am Resident #5 stated he didn't know anything about any medication left for him in a drawer. When asked about the pain medication Resident #5 stated that he didn't like to take it and that the medication had been discontinued. The nurses were really good about giving his my medications when they were due. During an interview on 04/01/2025 at 9:50am CNA A stated she saw LVN B throw narcotics into the trash can on the medication cart. CNA A stated to LVN B there was a drug buster and was how narcotics were destroyed. LVN B replied to CNA A she forgot and would destroy them that way the next time. The 2nd time LVN B discarded a narcotic in the trash can on the medication cart, CNA A made the ADM aware. Both of these wastes of narcotics were for Resident #2. During an interview on 04/01/2025 at 11:09am Resident #2 stated LVN B was supposed to give her meds, but she never gave it to her. Resident #2 stated she had to ask for pain medications because it was PRN. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 04/01/2025 at 11:41am DON stated the narcotic discrepancies were with Resident #2, Resident #5, and Resident #6. DON stated narcotics for Resident #2 were thrown away in the trash can on the medication cart, and the narcotic discrepancies for Resident #5 and Resident #6 were the narcotics were left in a bedside night stand drawer or on a meal tray. DON stated she performed a narcotic audit of medications at that time. DON stated she asked LVN B where the narcotics were for Resident #5 due to medication being signed out before the end of her shift. LVN B stated she had put them in Resident #5's top drawer of his night stand. DON stated that there was another narcotic sheet that revealed that Resident #5 had 20 Hydrocodone in the medication card, however when the card was visualized it only had a count of 17. LVN B was asked where the pills were, she stated to the DON that she had already gave them to Resident #5. DON stated she interviewed Resident #5 and he had not taken the medication due to him not liking the medication. DON then proceeded to interview Resident #6 regarding medication being on her meal tray (lunch) and Resident #6 stated she had not taken any medication and had not seen any medication on the tray. During a phone interview on 04/01/2025 at 3:23 pm LVN B stated the following: I went to go and pull the meds like I normally do. One resident (Resident #2) was out of facility, and I was in the habit of pulling a Tylenol 3 and placing it in her top drawer of her night stand. This was only the 2nd time that I had done it. The only reason that it happened on Thursday was due to Resident #2 being very tearful and in pain LVN B stated that a negative outcome for preparing a narcotic for a resident and then leaving the medication was we just aren't supposed to do it. That side is very heavy when it comes to med pass, and I know that we are not supposed to do it. LVN B was asked about the medication for Resident #5 and Resident #6; LVN stated the Resident #6 would ask for the medications to be left on bedside table, since she [NAME] her medications one at a time. LVN B stated she did ask if the resident would take the narcotic first and then the resident could take the remainder of her medications on her own. LVN B stated that Resident #5 was starting to move around more and since Resident #5 was eating, LVN B placed the medication in the top drawer of the night stand and when the DON asked her where she put it she went to go and get the medication out of the drawer and the medication was not found. LVN B stated the negative outcome of not staying with residents until medications is taken is that there is no proof that the resident took the medication. LVN B also stated the negative outcome of placing medications in nightstand drawers it is not in our profession, and we are taught not to do that. LVN B stated the reason why she did this was because that the day was just overwhelming, I went with HR to have a drug screen, but I have nothing to hide. During an interview on 04/01/2025 at 4:14pm ADM stated LVN B would be terminated and reported to the Texas Board of Nursing. Copies of those reports were requested by investigator. During an interview on 04/02/2025 at 9:43am DON stated a possible negative outcome of a nurse not staying with a resident to watch the resident take the medication, was that resident's pain would not be addressed and resident not taking the medication and someone else taking it. DON stated the negative outcome of having an incompetent nurse would lead to the safety of residents, and the nurse not following the 5 rights of medication administration and adequate to follow up on resident's to assess if the medication was effective. During an interview on 04/02/2025 at 11:36am Resident #6 stated she never had anyone place medication on her meal tray or in any of her nightstand drawers. Resident #6 stated I just take what they give me. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675904	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windflower Health Center	5500 SW 9th Ave Amarillo, TX 79106

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of facility provided policy, titled, Administering Medications, revised April 2019, revealed the following: .5. Medications are administration times are determined by resident need and benefit, not staff convenience. .7. Medications are administered within one (1) hour of their prescribed time, . Record review of facility provided policy titled, Staffing, Sufficient and Competent Nursing revised August 2022, revealed the following: .Competent Staff 1. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. 2. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. 3. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas: a. Resident rights; . .g. Basic nursing skills; . .j medication management; . .k. pain management; .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on interview, and record review, the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have acess to the keys for 3 of 10 residents (Resident #2, Resident #5, and Resident #6) reviewed for medication storage. -The facility failed to ensure LVN B stayed with Resident #6 until narcotic medications were taken. -The facility failed to ensure LVN B did not place narcotics in the nightstand table of Resident #5 and Resident #6's meal tray. -The facility failed to ensure LVN B did not destroy narcotic medications for Resident #2, by throwing them away in the medication cart trash can. These failures could place residents at risk for drug diversion, lack of drug efficacy, and adverse reactions. Findings included: During an interview on 04/01/2025 at 9:50am CNA A stated she saw LVN B throw narcotics into the trash can on the medication cart. CNA A stated to LVN B there was drug buster and that was how narcotics were destroyed. CNA A stated that LVN B told her (CNA A) that she (LVN B) forgot and would destroy them that way the next time. CNA A stated that the 2nd time she saw LVN B discarded a narcotic in the trash can on the medication cart, CNA A reported to the ADM. Both of these wastes of narcotics were for Resident #2. During an interview on 04/01/2025 at 11:09am Resident #2 stated LVN B was supposed to give her meds, but she never gave it to her. Resident #2 stated she had to ask for pain medications because it was PRN. Record Review of Resident #2's MDS, dated [DATE], revealed Resident #2's BIMS score was 15 out of 15 which indicated that Resident #2 did not have any cognitive deficits. Record review of Resident #2's order summary, dated 04/02/2025, revealed Resident #2 had an order for (Tylenol 3) Acetaminophen-Codeine Tablet 300mg/30mg-Give 1 tablet by mouth every 6 hours as needed for severe pain. This order had a start date of 01/16/2025 and was open ended. Record review of Resident #2's medication administration record, dated 03/01/2025-03-31/2025 revealed that Resident #2 received her Tylenol 3 at 8:00am and 1:00pm on 03/27/2025 with the initials of LVN B recorded as the administer of the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's narcotic count sheet dated 03/21/2025-03/27/2025, revealed that LVN B dispensed 1 Tylenol 3 tablet on 03/23/2025 with an entry of dropped, another entry on 03/26/2025 of dropped, and 03/27/2025 nurse found, medication wasted. During an interview on 04/01/2025 at 11:41am DON stated the narcotic discrepancies were with Resident #2, Resident #5, and Resident #6. DON stated narcotics for Resident #2 were thrown away in the trash can on the medication cart, and the narcotic discrepancies for Resident #5 and Resident #6 were the narcotics were left in a bedside night stand drawer or on a meal tray. DON stated she performed a narcotic audit of medications at that time. DON stated she asked LVN B where the narcotics were for Resident #5 due to medication being signed out before the end of her shift. LVN B stated she had put them in Resident #5's top drawer of his night stand. DON stated that there was another narcotic sheet that revealed that Resident #5 had 20 Hydrocodone in the medication card, however when the card was visualized it only had a count of 17. LVN B was asked where the pills were, she stated to the DON that she had already gave them to Resident #5. DON stated she interviewed Resident #5 and he had not taken the medication due to him not liking the medication. DON then proceeded to interview Resident #6 regarding medication being on her meal tray (lunch) and Resident #6 stated she had not taken any medication and had not seen any medication on the tray. During a phone interview on 04/01/2025 at 3:23 pm LVN B stated the following: I went to go and pull the meds like I normally do. One resident (Resident #2) was out of facility, and I was in the habit of pulling a Tylenol 3 and placing it in her top drawer of her night stand. This was only the 2nd time that I had done it. The only reason that it happened on Thursday was due to Resident #2 being very tearful and in pain LVN B stated that a negative outcome for preparing a narcotic for a resident and then leaving the medication was we just aren't supposed to do it. That side is very heavy when it comes to med pass, and I know that we are not supposed to do it. LVN B was asked about the medication for Resident #5 and Resident #6; LVN stated the Resident #6 would ask for the medications to be left on bedside table, since she [NAME] her medications one at a time. LVN B stated she did ask if the resident would take the narcotic first and then the resident could take the remainder of her medications on her own. LVN B stated that Resident #5 was starting to move around more and since Resident #5 was eating, LVN B placed the medication in the top drawer of the night stand and when the DON asked her where she put it she went to go and get the medication out of the drawer and the medication was not found. LVN B stated the negative outcome of not staying with residents until medications is taken is that there is no proof that the resident took the medication. LVN B also stated the negative outcome of placing medications in nightstand drawers it is not in our profession, and we are taught not to do that. LVN B stated the reason why she did this was because that the day was just overwhelming, I went with HR to have a drug screen, but I have nothing to hide. During an interview on 04/01/2025 at 4:14pm ADM stated LVN B would be terminated and reported to the Texas Board of Nursing. Copies of those reports were requested by investigator. During an interview on 04/02/2025 at 9:43am DON stated a possible negative outcome of a nurse not staying with a resident to watch the resident take the medication, was that resident's pain would not be addressed and resident not taking the medication and someone else taking it. DON stated the negative outcome of having an incompetent nurse would lead to the safety of residents, and the nurse not following the 5 rights of medication administration and adequate to follow up on resident's to assess if the medication was effective. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/2025 at 11:36am Resident #6 stated she never had anyone place medication on her meal tray or in any of her nightstand drawers. Resident #6 stated I just take what they give me. Record review of Resident #5's most recent MDS, dated [DATE], revealed Resident #5's BIMS of 15 out of 15 which indicates that Resident #5 had no cognitive deficits. Record review of Resident #5's order summary, dated 04/02/2025, revealed Resident #5 had an order for Hydrocodone-Tylenol Tablet 10mg/325mg-Give 1 tablet by mouth every 8 hours as needed for pain. This order has a start date of 04/10/2024 and discontinue date of 03/28/2025. Record review of Resident #5's medication administration record, dated 03/01/2025-03-31/2025 revealed that Resident #5 received his Hydrocodone-Tylenol 10mg/325mg at 7:00am and 1:00pm on 03/27/2025 with the initials of LVN B recorded as the administer of the medication. Record review of Resident #5's narcotic count sheet dated 03/23/2025-03/27/2025, revealed that LVN B dispensed 1 hydrocodone-Tylenol 10mg/325mg tablet with no time next to date and signature. Document further revealed the medication was placed in drawer/missing, next to entry. Record Review of Resident #6's MDS, dated [DATE], revealed Resident #6's BIMS score was 15 out of 15 which indicated Resident #6 did not have any cognitive deficits. Record review of Resident #6's medication administration record, dated 03/01/2025-03/31/2025 revealed Resident #6 received her hydrocodone-acetaminophen 10mg-325mg tablet at 8:00am and 12:00pm on 03/27/2025 with the initials of LVN B recorded as the administer of the medication. Record review of Resident #6's narcotic count sheet dated 03/27/2025-03/29/2025, revealed that LVN B dispensed 1 hydrocodone-acetaminophen 10mg-325mg tablet with entry for 4:00pm dose missing. Record review of facility provided policy titled, Discarding and destroying Medications, revised November 2022, revealed the following: .1. All unused controlled substances are retained in a securely locked area with restricted access until disposed of. Record review of facility provided policy titled, Administering oral Medications revised October 2010, revealed the following: .21. Remain with the resident until all medications have been taken. Record review of facility provided policy, titled, Administering Medications, revised April 2019, revealed the following: .5. Medications are administration times are determined by resident need and benefit, not staff convenience. .7. Medications are administered within one (1) hour of their prescribed time, .