STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	1618 Kirby Rd Carrollton, TX 75006

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to provide residents with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one (Resident #45) of five residents reviewed for call lights. The facility failed to ensure Resident #45's call light was accessible. This failure could place the residents at risk of falling, further injury, and unnecessary pain from not being able to call for help. Findings included: Review of Resident #45's face sheet, dated 04/11/24, reflected the resident was a [AGE] year-old female who was originally admitted on [DATE] and readmitted on [DATE]. Her diagnoses included metabolic encephalopathy (a brain disorder caused by various diseases or toxins that affect the body's chemistry and disrupt the brain's function), acute kidney failure (a sudden condition where the kidneys lose their ability to filter waste products from the blood), and adjustment disorder with anxiety (a mental health condition that arises due to difficulty coping with significant life changes). Review of Resident #45's quarterly MDS assessment, dated 03/26/24, revealed there was not a BIMS score calculated for her. Review of Resident #45's care plan, dated 03/17/24, reflected the following: Focus: At risk for falls r/t Deconditioning, Gait/balance problems, Unaware of safety needs .Goal: Will not sustain serious injury through the review date .Interventions: Be sure the call light is within reach and encourage to use it to call for assistance as needed. Observation on 04/09/24 at 10:33 AM revealed Resident #45 was in her room sleeping in bed. Resident #45's call light was placed on top of the light above her bed, out of reach. Observation on 04/10/24 at 10:20 AM revealed Resident #45 was in her room sleeping in bed. Resident #45's call light was placed on top of the light above her bed, out of reach. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/10/24 at 11:30 AM with LVN T revealed Resident #45's call light was placed on top of the light above her bed and out of her reach. LVN T said she was not sure why Resident #45's call light was on top of the light and did not notice it this morning when she checked on the resident. LVN T said the call light should always be where a resident could reach it. She stated everyone, including CNAs and nurses, were responsible for ensuring it was within the resident's reach. LVN T said the purpose of the call light was for the resident to call when they needed something. LVN T said the risk of a call light not being within reach was that an injury could happen, or the resident could miss out on food or drinks if they needed them. Interview on 04/11/24 at 3:22 PM with the DON revealed call lights should be within reach of the resident, and she was not sure who placed Resident #45's call light on the light above her bed. The DON said Angel Rounds were completed every morning, so it was the assigned Angel's responsibility to have noticed the call light placement, and if not, then the CNAs or nurses caring for her. The DON said the purpose of the call light was for the resident to be able to alert staff if they needed any assistance. The DON said the resident might have an emergency or a fall and staff would not know about it right away. Review of the facility's Call Lights/Bell policy, revised 08/03/21, reflected: .4 .Place the call device within resident's reach before leaving room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment for 1 of 2 residents (Resident #46) reviewed for physical environment. The facility failed to ensure Resident #46's gastronomy tube (a tube placed through the abdominal wall with the aid of an endoscope into the stomach used for feeding patients unable to swallow food) pole and floor was clean. These failures could place the residents at risk for the spread of infection and disease, a diminished quality of life and a diminished clean, homelike environment. Findings included: Review of Resident #46's face sheet, dated 04/11/24, revealed the resident was a [AGE] year-old-female who admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnoses included gastrostomy status (surgical procedure for inserting a tube through the abdomen wall and into the stomach, used for feeding), epilepsy (seizure disorder) and dysphagia (difficulty swallowing). Review of Resident #46's comprehensive MDS assessment, dated 03/19/24, revealed her BIMS score was 0, indicative of severe cognitive impairment. Resident #46's nutritional approach was feeding tube. Observation on 04/09/24 at 10:29 AM revealed Resident #46 lying in bed sleeping. A feeding pump was next to Resident #46's bed and was infusing. A bottle of enteral feeding was hanging from the pole with dried formula spills on the floor and pole, and there were trash behind the oxygen tank and under the bed. Observation and interview on 04/10/24 at 1:00 PM with LVN B revealed she was the nurse assigned to Resident #46. She stated g-tube poles were supposed to cleaned by the nurse on duty any time they spill the formula. She stated she had not noticed the g-tube poles being dirty. LVN B entered Resident #46's room and stated the g-tube poles and the floor around the g-tube poles were dirty and filthy. he stated she had not noticed the poles, or the floors had dried formula and trash behind the oxygen tank and under the bed when she assists the resident. She stated the potential risk of g-tube poles being dirty could be infection control. Observation/ Interview on 04/10/24 at 01: 20PM with the Housekeeper revealed she was the housekeeper assigned for the 200 hall. She stated she had noticed Resident #46's floor having plastic caps and g-tube pole to be dirty. She stated she had cleaned the room several times; however, the dried formula was hard to remove and also, she had not been cleaning under the bed because she only does that when performing deep cleaning . She stated dried formula piled up, and she had not she had not notified the housekeeping director that nurses were throwing the trash on the floor behind the oxygen tank and under the bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation/ Interview on 04/11/24 at 02:15 PM with the Housekeeping Director revealed he could see the trash behind the oxygen tank and under the floor and also dried formula on the pole and the floor of Resident #46's room. He stated his expectation was for his staff to clean the room properly and in case of any problem to let him know. He stated he was not aware staff were putting trash behind the oxygen tank and under the bed. He stated he expected the housekeeper to move the oxygen tank, clean the area, clean under the bed, and ask for assistance to move the bed. Interview on 04/11/24 on 3:14 PM with the DON revealed nurses were responsible for cleaning the g-tube poles, and the housekeepers were responsible for cleaning the floors. She stated nurses should be wiping the spills down. She stated the potential risk was that it could be unsanitary. Record review of the facility's Comfortable Home Like Environment, dated January 2022, reflected the following: .2 .The facility staff and management shall miximize.to the extent possible. The characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 1 of 5 residents (Resident #63) reviewed for MDS assessment accuracy in that: Resident #63's quarterly MDS assessment dated [DATE] was coded incorrectly in that it indicated she had a wound infection when she did not. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Review of Resident #63's face sheet, dated 04/11/24, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and cognitive communication deficit (problems with communication that have an underlying cause in a cognitive deficit rather than a primary language or speech deficit). Review of Resident #63's quarterly MDS assessment, dated 01/10/24, reflected no BIMS score was indicated. Further review reflected Resident #63 had a wound infection. Review of Resident #63's physician's orders, dated 01/01/24 to 04/30/24 revealed there were no orders for a wound or wound infection. Interview using a translator app on 04/09/24 at 10:42 AM with Resident #63 revealed she did not want to talk to the surveyor. Interview on 04/09/24 at 2:29 PM with the DON revealed Resident #63 did at some point during her stay at the facility had a hip replacement where a wound was infected but she was not sure when that was. Interview on 04/10/24 at 11:30 AM with LVN T revealed she was caring for Resident #63 and had been for a while now. LVN T said Resident #63 did not have any wounds or infected wounds since she had been caring for her. Interview on 04/11/24 at 10:29 AM with MDS Coordinator V revealed she found out about Resident #63's incorrect MDS assessment yesterday (04/10/24) when the DON asked her about it. MDS Coordinator V said she looked into it and saw that Resident #63 was incorrectly triggered for a wound infection, but it had been resolved already. MDS Coordinator V said MDS Coordinator U was the one who completed that section on Resident #63's MDS assessment where the wound infection was incorrectly triggered. MDS Coordinator V said the purpose of the MDS was to capture a resident's level of care being provided by the facility. MDS Coordinator V said the person completing the MDS assessment should make sure it was accurate but that there was not anyone who looked over the completed MDS assessments for accuracy. MDS Coordinator V said the inaccurate MDS assessment would not give a whole complete picture of the resident's level of care. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 04/11/24 at 11:24 AM with MDS Coordinator U revealed she completed Resident #63's MDS assessment from January 2024. MDS Coordinator U said she did not catch that Resident #63's wound infection had resolved after it automatically prepopulated from the last MDS assessment. MDS Coordinator U said she was responsible for ensuring the information in that section was accurate before it was completed. Review of the facility's Resident Assessment and Associated Processes policy, dated March 2022, reflected: It is the policy of this facility that resident's will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproductible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified .7. Each individual who completes a portion of the assessment will electronically sign and certify the accuracy of that portion of the assessment, as well as the date the data was obtained [sic].

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure residents received parenteral fluids administered consistent with professional standards of practice and in accordance with physician orders for 2 of 4 resident (Resident #52 and Resident #3) reviewed for peripheral intravenous care. The facility did not ensure Residents #52's and #3's PICC line dressings were changed per the physician's order. This failure placed residents at risk of developing an infection. Findings included: Review of Resident #52's face sheet, dated 04/11/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included aftercare following joint replacement surgery, infection and inflammatory reaction due to internal right knee prosthesis, hypokalemia (low potassium), and essential hypertension (high blood pressure). Review of Resident #52's Admission MDS assessment, dated 03/05/24, reflected a BIMS score of 15 indicating no cognitive impairment. The MDS further revealed Section O: Special Treatments, Procedures and Programs resident was receiving IV Medications. Review of Resident #52's care plan, undated, reflected Focus: Has infection r/t s/p left knee infected arthroplasty - on IV ATB X2 until 04/08/24. Goal: Will be free from complications related to infection through the review date. Interventions: Administer antibiotics as per MDS orders. Focus: Is on IV Medications r/t s/p infected left knee revision. Goal: Will not have any complications related to IV Therapy through the review date. Interventions: Check dressing at site daily. Labs as ordered. Review of Resident #52's physician's orders as of 03/01/24 reflected an order for PICC line Care: Change PICC Line Dressing Q7 Days if site is visible for assessment. Change dressing PRN if wet, soiled, saturated or loose. As needed. Order start date was 03/01/24. Review of Resident #52's physician's orders as of 03/01/24 reflected an order for PICC Line Care: Change PICC Line dressing Q7 days if site is visible for assessment. Change Dressing PRN if wet, soiled, Saturated or Loose. Every night shift every Fri. Order start date was 03/01/24. Review of Resident #52's March 2024 MAR/TAR revealed the dressing was changed on 03/29/24. Review of Resident #52's April 2024 MAR/TAR revealed there was no indication the dressing was changed on Friday 04/05/24 because it was left blank. Review of Resident #3's face sheet, dated 04/11/24, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included fracture of superior rim of right pubis (bones in pelvis), subsequent encounter for fracture with routine healing, spondylolisthesis lumbar region (spinal column fracture) and elevated white blood cell count. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's care plan, undated, reflected Focus: Has infection r/t s/p left knee infected arthroplasty - on IV ATB X2 until 04/08/24. Goal: Will be free from complications related to infection through the review date. Interventions: Administer antibiotics as per MDS orders. Focus: Is on IV Medications r/t s/p infected left knee revision. Goal: Will not have any complications related to IV Therapy through the review date. Interventions: Check dressing at site daily. Labs as ordered. Review of Resident #3's Admission MDS assessment, dated 03/22/24, reflected a BIMS score of 15 indicating no cognitive impairment. Review of Resident #3's care plan, undated, reflected Focus: Is on Antibiotic Therapy r/t bronchitis. Goal: Will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions: Administer medication as ordered. Review of Resident #3's physician's orders as of 03/27/24 reflected an order for Central Line/Midline care: change central line/Midline Dressing Q3 days if not visible for assessment. Change dressing PRN if wet, soiled, saturated, or loose every day shift every 3 days (s) for midline for 8 days. Oder date 03/27/24. Review of Resident #3's March 2024 MAR/TAR revealed the dressing was changed on 03/31/24. Review of Resident #3's April 2024 MAR/TAR revealed there was no indication the dressing was changed on Wednesday 04/03/24 because it was left blank. Observation and interview on 04/09/24 at 10:51 AM with Resident #52 revealed she was sitting in her bed, and she stated she was doing well. Resident #52 had a PICC line in her left upper arm covered with a transparent dressing. The transparent dressing was dated 03/29/24. There was no redness, drainage, or swelling to the resident's left arm. Resident #52 stated she had knee replacement survey, and she was on antibiotics due to an infection on her left knee. Resident #52 stated her dressing had not been changed in the last week. She stated the date on the dressing was the last time it was changed, and she did not remember which staff had changed it. Resident #52 stated today 04/09/24 was her last day for antibiotics. Resident #52 denied any pain or discomfort. Observation and interview on 04/09/24 at 1:49 PM with Resident #3 revealed she was sitting in her wheelchair, and she stated she was doing well. Resident #3 had a mid-line in her left upper arm covered with a transparent dressing. The transparent dressing was dated 03/30/24. There was no redness, drainage, or swelling to the resident's left arm. Resident #3 stated she was on antibiotics due to a cough. Resident #3 stated she had been done with her antibiotics for a couple of days now. She stated she did not know when they would be removing her midline. Resident #3 denied any pain or discomfort. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/09/24 at 2:34 PM with LVN A revealed she was the nurse assigned to Resident #3 and Resident #52. LVN A stated she was aware Resident #3's dressing needed to be changed. She stated she was waiting on another nurse to come assist her. LVN A stated Resident #52's PICC Line dressing needed to be changed every 7 days; however, she was unsure about Resident #3. She stated she had not changed Resident #3 and Resident #52's dressings in the last week. LVN A reviewed Resident #52 physician orders and MAR. She stated according to documentation Resident #52 dressing was last changed was on 03/29/24. She stated it needed to be changed on 04/05/24. She stated she was unaware and did not observe the date on the dressing when Resident #52's antibiotics were administered. LVN A stated she was unsure about Resident #3 physician orders. She stated she reviewed Resident #3's clinical records and could not locate physician orders. She stated Resident #3 completed her antibiotics on 04/05/24. LVN A stated she was going to get clarification on Resident #3 orders. She stated the potential risk for not changing PICC line/midline dressing was that it could cause an infection. Follow-up interview on 04/09/24 at 3:35 PM with LVN A revealed she received a physician order to remove midline. Interview on 04/11/24 at 3:06 PM with the DON revealed her expectation was for nurses to be checking the PICC lines every shift, flush before and after medication and to change the dressing every 7 days and as needed if soiled. The DON stated the PICC line dressing should be dated. She stated she had not changed any PICC line dressings in the last week and was unaware when was the last time Resident #3 and Resident #52's dressings were last changed. She stated the LVNs were responsible for changing and dating the dressings. The DON stated it was her responsibility to ensure PICC line dressings were being changed and dated. The DON stated the potential risk of not following physician orders was that it could lead to an infection. Record review of facility's PICC line dressing change policy, dated July 2013, reflected the following: Dressing Change Policy: The transparent dressings are changed every 7 days and sooner when it becomes loosened to the point of compromising sterility or presents a risk of accidental dislodgement of the catheter.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on interview and record review, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for 1 of 1 resident (Resident #49) reviewed for unnecessary medications, and medication regimen review. The facility's Pharmacist Consultant recommended Residents #49's Lidocaine External Patch 4 % (Lidocaine) required to be updated to read wear 12 hours and then off 12 hours. This failure could place residents on lidocaine patch at risk for possible adverse side effects, adverse consequences, and decreased quality of life. Findings included: Record review of Resident #49's face sheet dated 04/11/24 revealed the resident was a [AGE] year-old female who originally admitted to the facility 05/18/21. The diagnoses included disorder of muscles and multiple sclerosis (disorder in which the body's immune system attacks the protective covering of the nerve cells in the brain, optic nerve, and spinal cord, called the myelin sheath). Record review of Resident #49's comprehensive MDS dated [DATE] revealed a BIMS score of 12 indicating she was moderately cognitive impaired. Review of Resident #49's physician's orders reflected an order for: Lidocaine External Patch 4 % (Lidocaine) Apply to left wrist topically one time a day for pain, with a start date of 05/01/23. Review of Resident #49's April 2024 MAR reflected the following: Lidocaine External Patch 4 % (Lidocaine) Apply to Left wrist topically one time a day for pain and indicated Resident #49 received the patch every day and there was no order for removal. Review of Resident #49's care plan, revised on 08/10/23, reflected: potential for pain rule out neuropathy, debility,chronic back pain. Goal: will voice a level of comfort of through the review date .Intervention: administer analgesia medication as per orders. Review of Resident #49's Medication Regimen Review, dated 05/23/23, reflected the following: Please Update lidocaine patch 4% order to include the following wear for 12 hours on, then 12 hours off. Interview on 04/11/24 on 3:18 PM with the DON revealed she was not aware the recommendation for Resident #49 had not been acted upon. The DON revealed reviewing Pharmacist Consultant's recommendations was primarily her responsibility. When she had an ADON, the ADON assisted but she did check over her work because she did not triple check. She stated she assumed when the pharmacy reviews were put on the binder they were completed. The DON stated when she received the recommendations, she went through them, updated the orders, and indicate it was done. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was asked to provide the facility's Drug Regimen Reivew policy on 04/11/24 at 4:00 PM, and the DON started they did not have a policy. She could not tell of any guidance that was being used.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to ensure residents are free of any significant medication errors for 1 of 3 residents (Resident #45) reviewed for medication administration. The facility failed to prevent Resident #45 from being provided Losartan Potassium, a medication designed to lower a person's blood pressure, while Resident #45 was assessed with blood pressure lower than the physician recommended parameters for providing the medication. This failure could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. Findings included: Review of Resident #45's face sheet, dated 04/11/24, reflected the resident was a [AGE] year-old female with an initial admitted [DATE] and admitted [DATE]. Her diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and essential hypertension (a form of high blood pressure. Review of Resident #45's quarterly MDS assessment, dated 03/26/24, reflected there was not a BIMS score calculated for her. Review of Resident #45's Order Summary Report, dated 04/11/24, reflected an order that read Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 2 tablet by mouth two times a day for Hypertension [high blood pressure] hold for sbp less than 110, dbp less than 60 or HR less than 60. Review of Resident #45's March 2024 Medication Administration Record, dated 04/11/24, reflected of the 62 times the resident was scheduled to be administered losartan, 4 doses were administered out of physician parameters with Resident #45's systolic blood pressure being under 110 and diastolic blood pressure being under 60: 03/05/24 at AM 07 when Resident #45's systolic blood pressure was 100 and diastolic blood pressure was 52 administered by MA W; 03/10/24 at AM 07 when Resident #45's systolic blood pressure was 108 administered by MA Y; 03/20/24 at HS 19 when Resident #45's systolic blood pressure was 107 and diastolic blood pressure was 52 administered by MA X; and 03/21/24 at AM 08 when Resident #45's systolic diastolic blood pressure was 58 administered by MA W; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675972	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Health and Rehabilitation Center	1618 Kirby Rd Carrollton, TX 75006

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #45's care plan, dated 03/17/24, reflected the following: Focus: potential for alteration in cardiovascular status r/t hypertension; Goal: will remain free of complications related to hypertension through review date.; Interventions: Blood pressure taken as ordered .Give anti hypertensive medications as ordered [sic]. Observation on 04/09/24 at 10:33 AM revealed Resident #45 was in her room sleeping in bed. Resident #45 did not wake up to the surveyor asking her questions. Interview on 04/10/24 at 11:38 AM with MA Z revealed he administered blood pressure medications to Resident #45. MA Z said he always referred to the parameters of the medications and checked Resident #45's blood pressure before he gave her the medication. MA Z said if the blood pressure was out of parameters, then he would let the nurse know about it and not give the medication. MA Z said he would document that the medication was not given on the resident's MAR using the number code but could not recall what that number was. MA Z said the purpose of this was to let others know that the medication was not given because the blood pressure was out of parameters. MA Z said anyone giving medications was responsible for ensuring that a medication was not given out of parameters. MA Z said if a medication was given out of parameters the blood pressure could be too elevated or too low because the resident will receive the medications. Interview on 04/11/24 at 3:22 PM with the DON revealed she saw that there was two medication aides who she noticed were giving Resident #45 her blood pressure medication out of parameters. The DON said she terminated one of the medication aides and he did not give a reason he administered the medication out of parameters. The DON said any medication should be held if the vitals were out of parameters. The DON said the medication aide should have notified the nurse and the nurse would have notified the doctor that the medication was not administered because the resident's vitals were out of parameters. The DON said the purpose of this was so that her blood pressure would not go too low to cause issues or any side effects. The DON said she was responsible for monitoring resident's MARs, but there were a lot of residents, and she was not able to review them all. Review of the facility's Medication Administration policy, dated May 2007, reflected: .2. Medications must be administered in accordance with the written orders of the attending physician.

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	675972	A. Building B. Wing	04/11/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42859 Based on observation, interview, and record review, the facility failed to ensure in accordance with State and Federal laws, they stored all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for 1 of 4 residents (Residents #36) reviewed for pharmacy services. The facility failed to ensure Resident #36 took her medications when they were administered, which resulted in the resident saving the medication in her room. This failure could place residents at risk of not receiving the therapy needed. Findings included: Review of Resident #36's face sheet, dated 04/11/24, revealed the resident was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included essential hypertension (high blood pressure) and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident #36's MDS assessment, dated 04/02/24, revealed a BIMS score of 0 which indicated her cognition was severely impaired. Record review of Resident #36's April 2024 MAR revealed Resident #36's was administered hydrocodone-acetaminophen tablet 5-325 mg. Give 1 tablet by mouth every 8 hours for pain and meclizine oral tablet 25 mg. Give 25 mg by mouth every 8 hours for dizziness and Simethicone capsule 125 mg. Give 1 capsule by mouth every 8 hours for bloating at 6.00 AM. Review of Resident #36's physician order, dated 02/20/23, reflected the following order for Simethicone capsule 125 mg. Give 1 capsule by mouth every 8 hours for bloating, on 10/04/23 meclizine oral tablet 25 mg. Give 25 mg by mouth every 8 hours for dizziness and on 02/23/24 revealed hydrocodone-acetaminophen tablet 5-325 mg. Give 1 tablet by mouth every 8 hours for pain. Observation and interview on 04/09/24 at 11:06 AM with Resident #36 revealed she had one white pill on her bed side table in a medication cup. Resident #36 stated the nurse left the medication cup, and she would take the medications when she was ready. Resident #36 stated it was one of her gas pills, and she did not mean to get anybody in trouble. She always took it when she was ready though, and the staff told her she needed to take it before breakfast. She did not want to disclose whether she was left with the medication in the morning during medication pass, she only stated one staff gave it to her. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/09/24 at 11:11 AM with MA C revealed a white pill on the Resident #36's bedside table. MA C stated the resident should not have any medication in her room. MA C stated he provided Resident #36's medication that morning, and he did not notice the pill in the cup. MA C stated medication should not be left unsupervised or left in the room. He stated the risk of leaving meds was that it could lead to another resident taking it. MA C stated he had been trained on medication administration. Observation and interview on 04/09/24 11:19 AM with LVN B revealed a white pill on the Resident #36's bedside table. LVN B stated the resident should not have any medication in her room. LVN D stated she provided care to Resident #36's that morning, and she did not notice the pill in the cup. She stated maybe she had covered it with something. LVN B stated medication should not be left unsupervised or left in the room. She stated the risk of leaving meds was that it could lead to another resident taking it. LVN B stated she had been trained on medication administration, but she could not know when. She stated she thought the night shift nurse, who was an agency nurse, could have been the one that left the pill in the room. Interview on 04/09/24 at 2:12 PM with CNA E revealed she saw the white pill on Resident #36's bedside table when she was serving breakfast that morning. CNA E stated she reported to her charge nurse that there was a pill in a cup in Resident#36's room, but she did not follow-up. CNA E stated Resident #36 should not have any medication in her room. She stated the risk of leaving medications was that it could lead to another resident taking it. Interview on 04/11/24 at 03:11 PM with the DON revealed her expectation was the nurse should not leave medication in resident rooms unsupervised. The DON stated it was the nurse's responsibility to ensure residents took all the pills before they left the room. She stated the risk of leaving medication unsupervised was other residents could take them which could cause side effects. She stated the nurse that left the medication was an agency nurse. She stated her expectation was that the agency nurses follow the procedure because they were oriented before they started working in the facility. She stated she had done training on medication administration, but no records were provided. Record review of facility's Medication Administration policy, dated May 2007, revealed it did not address resident supervision until the resident took the medication they were given.