STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676037	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weslaco Nursing and Rehabilitation Center	422 E 18th St Weslaco, TX 78596

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761 Based on interview and record review, the facility failed to ensure residents have the right to request, refuse, and or discontinue treatment and to formulate an advance directive for 2 (Resident #23 and Resident #61) of 11 residents whose records were reviewed for Out-of-Hospital Do-Not-Resuscitate Order forms in that:resident rights. The Facility did not ensure Resident #23 nor Resident #61's OOH-DNR form was completed fully and correctly. This failure could place residents at risk of not having their code status wishes met in the event they were needed. The findings included: 1.Record review of Resident #23's face sheet with an admitted [DATE] reflected he was an [AGE] year-old male with diagnoses of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), diabetes, and hypertension. Record review of Resident 23's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 15 which indicated Resident #23 was cognitive intact. Record review of Resident #23's Comprehensive Care Plan dated [DATE] reflected: Focus: Resident #23 is a DNR dated [DATE] Goal: Facility will comply with resident/family wishes Date Initiated: [DATE] Target Date: [DATE] Interventions/Task: If resident has a cardiac arrest, do not call 911 or initiate CPR. Notify MD/RP and follow instructions after notification Date Initiated: [DATE] -Keep resident as comfortable as possible at all times Date Initiated [DATE] -Social services consult if resident/family want to change code status Date Initiated: [DATE]. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #23's OOH-DNR form dated [DATE] reflected no physician signature under Physician's Statement. 2. Record review of Resident #61's Admission Record dated [DATE] reflected he was a [AGE] year-old male admitted to the facility on [DATE], with the diagnoses which included cerebral infarction (stroke), quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypertension (high blood pressure), and gastrostomy status (placement of a feeding tube through the skin and the stomach wall). Record review of Resident #61's Quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 11 which indicated Resident #61 had moderate cognitive impairment. Record review of Resident #61's Care Plan dated [DATE] reflected: FOCUS: o Resident is a DNR Date Initiated: [DATE] GOAL: o Facility will comply with resident/family wishes Date Initiated: [DATE] Target Date: [DATE] INTERVENTIONS/TASKS: o If resident has a cardiac arrest, do not call 911 or initiate CPR. Notify MD/RP and follow instructions after notification Date Initiated: [DATE] LN o Keep resident as comfortable as possible at all times Date Initiated: [DATE] LN o Social services consult if resident/family want to change code status Date Initiated: [DATE] Social services Record review of Resident #61's Physician's Orders reflected an active order dated [DATE] for a code status of DNR (Do Not Resuscitate). Record review of Resident #61's OOH-DNR form dated [DATE] reflected no physician signature under Physician's Statement. In an interview on [DATE] at 02:26 p.m., MDS LVN T stated the social worker oversaw obtaining DNR forms. MDS LVN T stated once the DNR form had the resident/RP and witness signature, the social worker would let MDS know, and they would update the resident's medical record to reflect their DNR status. MDS LVN T stated if the DNR form had been uploaded, signed by resident/RP and witnesses, it was considered a valid form. She stated if a resident coded, the nurse would check PCC face sheet and under miscellaneous to make sure the resident/RP and witnesses signed the DNR. She said she was not sure if the nurses would check for the physician's signature. MDS LVN T stated the social worker would also inform medical records of a resident's DNR status and they would assist in obtaining physician's signature. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 02:40 p.m., MR Q stated when a resident was a DNR, the social worker was responsible for obtaining the DNR form. She stated once the resident/RP and witnesses signed the DNR form, she would inform MDS so they could update resident's records. MR Q said the social worker would place the DNR form in a binder that was kept in the nurse's station to make it readily available for the physician. MR Q said the social worker would inform medical records so they could also assist in obtaining the physician's signature. MR Q said she usually gave the physician 72 hours to sign the DNR form and if they did not sign within that time, she would contact them. She said there had been times in which she had to meet the physician outside the facility to acquire their signature. MR Q said when a resident codes, the nurses would check PCC under face sheet and under miscellaneous. MR Q stated as long as the DNR form had been uploaded, signed by resident/RP and witnesses, they will honor the resident's DNR status. In an interview on [DATE] at 11:22 a.m., SW U (from sister facility) said the facility's social worker, who was on vacation, was responsible for obtaining the DNR form. She stated the social worker would discuss advanced directives with resident/RP upon admission and upon their request thereafter. SW U said she would explain the process and if they wanted to pursue a DNR status, she would obtain the resident/RP signature and 2 witnesses. SW U said after the resident/RP and witnesses' signatures were obtained, she would notify the charge nurse for a change of code status. SW U said the charge nurse would contact the physician and obtain a verbal order. SW U stated after that, she would give the DNR form to medical records for them to have it ready for the physician to sign. SW U stated she did not know how much time a physician was given to sign the DNR form but said she would try to obtain the physician's signature within 72 hours. SW U stated if a resident codes, nursing staff would check PCC's face sheet and under miscellaneous to see if the DNR form had been signed by resident/RP and witnesses, and if it had, they would honor the DNR status and the DNR form would be considered a valid form even if it did not have a physician's signature. In an interview on [DATE] at 03:00 p.m., ADON RN E said when a resident coded, the nurse would check PCC's face sheet and under miscellaneous for the DNR. ADON RN E stated the nurse should know not to rely solely on PCC, they also needed to check the binder by the nurse's station to make sure the resident's DNR form had all required signatures. ADON RN E said all DNR forms that were in the binder by the nurse's station should have a physician's signature. She said the SW was responsible for maintaining the binder up to date. ADON RN E said medical records also assist in obtaining the physician's signature, but ultimately it was the SW's responsibility. ADON RN E said the SW wouldill give the physician 3 days to come in and sign the DNR form, if it were not signed within 3 days, the SW and medical records would start calling the physician to remind them their signature was needed. ADON RN E said if a resident coded and the DNR form was not signed by the physician, it would not be honored. ADON RN E said the nurse will call their family to see what they say. ADON RN E said if they could not get a hold of family, their DNR status would not be honored. On [DATE] at 05:10 p.m., the Administrator and Clinical Resources Nurse stated they did not have a policy concerning DNRs. 47828

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, including injuries of unknown source were reported immediately to the State Survey Agency, within two hours, if the events that cause the allegation involve abuse or result in serious injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury for 1 residents (Resident #49) of 4 residents reviewed. The facility failed to report within 24 hours, the allegations of resident abuse to the State Survey Agency for Resident #49. This failure could place all residents at increased risk for potential abuse and neglect due to unreported allegations of abuse and neglect. The findings included: Record review of Resident # 49's face sheet dated 03/14/2024 with an admission of 02/21/2018 and an initial admitted [DATE] reflected she was an [AGE] year-old female with diagnoses of Alzheimer's disease, dementia, major depressive order, anxiety, and bipolar. Record review of Resident #49's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 03 which indicated impaired cognition. Record review of Resident #1's face sheet dated 03/14/2024 with an admitted [DATE] and an original admitted [DATE] and a discharge date of [DATE] reflected he was a [AGE] year-old male with diagnoses of congestive heart failure, chronic kidney disease, and dementia. Record review of Resident #1's quarterly MDS assessment reflected he had a BIMS score of 07 which indicated he was moderately impaired cognition. Record review of Resident #49's Provider Investigation Report reflected on 08/24/2023 at 10:30 a.m., Resident #1 and Resident #49 were sitting in their wheelchair next to each other on the 200 hall. Staff observed Resident #1 rubbing his hand over Resident #49's breast area over the top of her clothing. Staff separated Resident #1 from Resident #49. Resident #1 was later moved to another hall. RP and PCP were notified. Facility did not report the incident because no allegations were made. On 08/25/2023 at about 4:00 p.m., Resident #49's RP called the facility and asked for the incident to be reported to the authorities as Resident #1's actions were not appropriate. Local police department was notified at 4:30 p.m. The investigation findings were unconfirmed for abuse. Record review of Incident Worksheet reflected the facility reported the incident on 08/25/2024 at 6:14 p.m. During an observation on 03/14/2024 at 10:25 a.m., Resident #49 was observed in her wheelchair in the dining room. She was well groomed and dressed in her own clothing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempted interview on 03/14/2024 at 10:30 a.m., Resident #49 was not interviewable. An interview on 03/14/2024 at 11:34 a.m., the Administrator/Abuse Coordinator said the incident between Resident #1 and Resident #49's was an interesting situation. He said when it was reported to him, the first impression was Resident #1 was the aggressor, but as they talked about it was determined Resident #49 was very friendly and invited human contact. The Administrator said there was no outcry from Resident #49. The Administrator said he called Resident #49's RP the next day (08/25/2023) and she got upset saying Resident #1 was a predator and that Resident #49 had been abused. The Administrator said, Resident #1 was immediately changed to another hall, they placed a blue flag on his wheelchair to help staff locate him at all times. The Administrator said Resident #1 had no history of inappropriate behavior or touching other residents. He said Resident #1 was transferred to another facility at family's request on 12/06/2023. The Administrator said he was familiar with the timeline of reporting incidents to state office and was not sure why he had not reported the incident Resident #49 timely. The Administrator did not say what the risks of not reporting incidents to state office in a timely manner were. Record review of facility's Abuse, Neglect and Exploitation policy dated 08/15/22 reflected: Policy: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Definitions: Abuse: means the willful infliction of injury, unreasonable confinement, intimidation, or punishment when resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, in respected are there any mental or physical condition, cause physical harm, he or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual Abuse: There's non-consensual sexual contact of any type with a resident. Neglect: Means failure of the facility, it's employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement with applicable) within specific timeframes: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Immediately, but not later than 2 hours after the allegation is made I f the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview, and record review, the facility failed to implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 1 of 4 residents (Resident #268) reviewed for care plans, in that: The facility failed to address, in Resident #268 baseline care plan, her feeding assistance upon admission. This failure could affect all newly admitted residents to the facility by placing them at risk of not receiving the care and services for health promotion and continuity of care. The findings included: Record review of Resident #268's face sheet with an admitted [DATE] reflected she was a [AGE] year-old female with diagnoses of severe protein-calorie malnutrition (is a severe form of malnutrition), kyphosis (an abnormality of the spine causing excessive curvature of the upper back causing pain and stiffness), and adult failure to thrive (a decline in health and functional abilities, often accompanied by weight loss, muscle wasting, fatigue and decreased quality of life. It can affect appetite, social activities, memory, and daily functions). Record review of Resident #268's baseline care plan dated 03/09/2024 reflected: 2. Eating: set up or clean-up assistance Record review of Resident #268's hospital order dated 03/05/2024 by OT indicated her current ADL was a maximum assist for eating assistance. Record review of Resident #268's hospital's order with a start date of 03/09/2024 with no end date called for a regular diet, pureed texture, regular liquids consistency. Record review of Resident #268's daily skilled noted dated 03/09/2024 at 6:23 p.m. authored by LVN N reflected eating: setup or clean up assistance. Record review of Resident #268's occupational therapy evaluation and plan of treatment dated 03/10/2024 reflected: Diagnoses: need for assistance with personal care. Functional skills assessment-activities of daily living and instrumental ADL's: Self feeding-total dependence without attempts to initiate. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 03/11/24 2:40 p.m., Resident # 268 was observed lying in bed, Resident #268 had pillows under her left and right arms and on her upper back. She was leaning/slouching forward towards her left side. Her head was dropped all the way to her upper chest. She was observed trying to hold her head up with her left hand but when she would put her hand down her head would drop. Resident #268 was observed being thin and frail. During an interview on 03/11/24 at 2:45 p.m., Resident #268 had difficulty speaking but managed to ask where she was. Resident #268 was not able to answer any questions related to her care An observation on 03/12/24 at 12:30 p.m., revealed Resident #268 was observed awake and sitting in a 45-degree angle and leaning/slouching to her left side. She had her food plate in front of her but was not eating. There were no CNA's assisting her. During an observation/interview on 03-12-24 at 1:30 p.m., CNA J was observed walking out of Resident #268's room with a meal tray. Surveyor asked CNA J who that tray belonged to, and she answered it belonged to Resident #268. CNA J removed the lid from the plate, and it was observed Resident #268 had not eaten anything. CNA J said Resident #268 only required supervision/encourage and did not require assistance with eating. CNA J said CNA's were responsible to inform the charge nurse when a resident does not eat 100 % of their meals. An interview on 03-12-24 at 1:32 p.m., Resident #268 said she was hungry and thirsty, she stated someone had taken her lunch tray away. Resident #268 said no one assisted in feeding her. An observation on 03-12-2024 1:40 p.m. COTA Q repositioned Resident #268. Resident #268 voiced to COTA Q that she was hungry and thirsty. Resident #268 pointed to the water cup on her bedside table and asked COTA Q to give her water, COTA Q told her she had to ask her nurse first. COTA Q walked out of room. An observation on 03-12-24 at 1: 45 p.m., COTA Q came back to Resident #268's room to tell her she had advised her nurse she was hungry and thirsty. COTA Q told Resident #268 her nurse had ordered her something to eat and drink and walked out of room. An observation on 03-24-24 at 2:03 p.m., dietary aide walked into Resident #268's room with a tray of oatmeal, milk, and water. At the same time, the dietary aide walked in, the Rehab Director walked in with CNA J and closed the door. An interview on 03-12-24 at 1:50 p.m., LVN N said when a new resident is admitted his/her charge nurse was responsible for the initial evaluation. She said during the initial assessment, the resident would be asked questions to determine the amount of assistance needed with their activities of daily living which include eating. She said they would ask the resident can you eat by yourself or need assistance. LVN N said if the resident is non-interviewable, they will follow the hospital recommendations until an OT evaluation is done. An interview on 03-13-2024 at 9:17 a.m., Rehab Director said when a new resident was admitted , and had an order for a therapy evaluation (occupational/speech/physical) they have between 1 to 3 days to be evaluated. The Rehab Director said if the resident is admitted on a Saturday they will be evaluated on Sunday. The Rehab Director said Resident #268 had been evaluated by an occupational and speech therapy on 03/10/2024. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 03/13/2024 at 11:15 a.m., OT S said she conducted an occupational assessment on Resident #268 on 03/10/2024. She said the assessment consisted of testing her ability to eat. OT S said Resident #268 was kyphotic and did not have the posture to feed herself. OT S said Resident #268 did not have the ability to look up at the table to see what was on it because she was not able to hold her head up. OT S said she and a cna sat Resident #268 on the side of the bed and her head was hanging. She said Resident #268 was too weak she was falling backwards and was not able to hold her position. OT S said she assessed her as a total dependence for all ADL's. OT S said Resident #268's cognition and mobility was poor. OT S said when she was done with Resident #268's assessment she told the charge nurse of her findings (she did not remember the name of the nurse). An interview on 03/13/2024 at 5:17 p.m., LVN O said she was the charge nurse on 03/09/2024 for the 2 pm to 10 pm shift. LVN O said when Resident #268 arrived from the hospital between 3:00-4:00 p.m., said she went to Resident #268's room to welcome and assess her. LVN O said Resident #268 told her she was hungry, and she ordered a dinner plate for her. LVN O said she followed the hospital orders for meals. LVN O said she stayed with Resident #268 until her meal tray arrived. LVN O said when her meal tray arrived, she sat her up and prepared the tray. LVN O said she witnessed Resident #268 trying to grab the utensils and managed to put some food in her mouth. LVN O said because she had witnessed Resident #268 trying to eat on her own, she verbally instructed the CNA's to supervise her meals. LVN O said by supervised meals she meant CNA's were to encourage the resident to eat and to inform the charge nurse of the percentage she ate. LVN O said she documented Resident #268's assessment on her progress notes under daily skilled note. An interview on 03/13/2024 at 5:30 p.m., ADON RN E said Resident #268 was admitted on [DATE]. She said when new residents were admitted on the weekend the facility would follow the orders from the hospital. ADON RN E said the charge nurse would also call the resident's physician to inform them of their admission and if they want the facility to resume the orders from the hospital. ADON RN E said charge nurse was the one responsible for calling the resident's physician as soon as the resident arrives to the facility. ADON RN E said Resident #268's hospital orders reflected she was a maximum assist for eating and LVN O should have instructed the CNA's Resident #268 required assistance in eating. ADON RN E said the charge nurse on the 10 p.m. -6:00 a.m. shift documented on her skilled nurse notes Resident #268 needed assistance with eating. Record review of facility's Baseline Care Plan policy dated 10/22/2022 and revised on 10/05/2023 reflected: Policy: The facility will develop and implement a baseline care plan for each resident that included the instruction needed to provide effective and person-centered care of the resident and meet professional standard of quality of care: 1. The baseline care plan will: b. Include the minimum healthcare information necessary to properly care for a resident including, but limited to: iii. Dietary orders (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident or resident representative, if applicable. b. Interventions shall be initiated that address the resident's current needs including: ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living, received the necessary services to maintain good nutrition for 1 of 4 (Resident #268) residents reviewed for ADL care. The facility failed to ensure Resident #268 received assistance with eating. These failure placed residents at risk of poor nutrition, and weight loss. The findings included: Record review of Resident #268's face sheet with an admitted [DATE] reflected she was a [AGE] year-old female with diagnoses of severe protein-calorie malnutrition (is a severe form of malnutrition), kyphosis (an abnormality of the spine causing excessive curvature of the upper back causing pain and stiffness), and adult failure to thrive (a decline in health and functional abilities, often accompanied by weight loss, muscle wasting, fatigue and decreased quality of life. It can affect appetite, social activities, memory, and daily functions). Record review of Resident #268's hospital order dated 03/05/2024 by OT indicated her current ADL was a maximum assist for eating assistance. Record review of Resident #268's hospital's order with a start date of 03/09/2024 with no end date called for a regular diet, pureed texture, regular liquids consistency. Record review of Resident #268's baseline care plan dated 03/09/2024 at 8:58 p.m. reflected: Eating: set up or clean-up assistance Record review of Resident #268's occupational therapy evaluation and plan of treatment dated 03/10/2024 reflected: Diagnoses: need for assistance with personal care. Functional skills assessment-activities of daily living and instrumental ADL's: Self feeding-total dependence without attempts to initiate. Record review of Resident #268's skilled nurses notes dated 03/10/2024 at 07:28 p.m., reflected Resident #268 was dependent for eating. Record review of Resident #268's Dietary Mini Nutritional assessment dated [DATE] at 5:52 p.m., reflected: Screening: had a moderate decrease in food intake, BMI less than 19. Resident #268 scored a 6.0 which indicated she was malnourished. (continued on next page)

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	676037	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weslaco Nursing and Rehabilitation Center	422 E 18th St Weslaco, TX 78596

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #268's SBAR dated 03/12/2024 at 1:25 p.m., reflected signs and symptoms of decreased meal intake. Nursing notes: call placed to NP due to resident with decreased meal intake new orders received to get dietary consult. Record review of Resident #268's weight history reflected she was weighed on 03/12/2024 at 3:16 p.m. and was 84 pounds. Record review of Resident #268's Dietician's Nutrition Therapy assessment dated [DATE] at 3:28 p.m., reflected % intake of meals as being poor and a dependent feeding ability. An observation on 03/12/24 at 12:30 p.m., Resident #268 was observed awake and sitting in a 45-degree angle and leaning/slouching to her left side. She had her food plate in front of her but was not eating. There were no CNA's assisting her. During an observation/interview on 03-12-24 at 1:30 p.m., CNA J was observed walking out of Resident #268's room with a meal tray. Surveyor asked CNA J who that tray belonged to, and she answered it belonged to Resident #268. CNA J removed the lid from the plate, and it was observed Resident #268 had not eaten anything. CNA J said Resident #268 only required supervision/encourage and did not require assistance with eating. CNA J said CNA's were responsible to inform the charge nurse when a resident does not eat 100 % of their meals. An interview on 03-12-24 at 1:32 p.m., Resident #268 said she was hungry and thirsty, stated someone had taken her lunch tray away. Resident #268 said no one assisted in feeding her. An observation on 03-12-2024 1:40 p.m. Surveyor observed Resident #268 voice to COTA Q that she was hungry and thirsty. Resident #268 pointed to the water cup on her bedside table and asked COTA Q to give her water, COTA Q told her she had to ask her nurse first. COTA Q walked out of room. In an interview on 03-12-24 at 1:50 p.m., LVN N said when a new resident is admitted his/her charge nurse is responsible for the initial evaluation. She said during the initial assessment, the resident will be asked questions to determine the amount of assistance needed with their activities of daily living which would include eating. LVN N said they asked the resident can you eat by yourself or need assistance with eating. LVN N said if the resident is non-interviewable, they will follow the hospital recommendations until an OT evaluation was done. LVN N said the CNA's are responsible to report to their charge nurse the percentage of food the resident eats. LVN N said, she had not been advised by her CNA's Resident #268 was not eating her meals. In an interview on 03/13/2024 at 9:58 a.m., the Dietary Manager said Resident #268's percentage of meal intakes were as follows: 03/09/2024 between 51-75% for dinner 03/10/2024 between 25-50% for breakfast, lunch and dinner resident refused 03/11/2024 between 51-75% for breakfast, 76-100% for lunch, and 26-50% for dinner 03/12/2024 between 0-25% for breakfast, 0-25 % for lunch, and 51-75% for dinner (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 03/13/2024 at 5:30 p.m., ADON RN E said CNA J should have assisted Resident #268 with her breakfast and lunch on 03/12/2024. ADON RN E said by not assisting Resident #268 with her meals, could result in weight loss. ADON RN E said LVN's have been trained to inform the CNA's on residents care. Record Review of the facility's Activities of Daily Living (ADLs) policy dated 05/26/23 reflected: Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and areas services will be provided for the following activities of daily living: 4. eating to include meals and snacks. Policy Explanation and Compliance Guidelines: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided with professional standards of practice for 2 of 3 residents (Resident #36 and Resident #57) reviewed for quality of care in that: 1. The facility failed to ensure Resident #36's oxygen was administered at 5.0 Lpm via trach mask as ordered by physician. 2. The facility failed to ensure Resident #36's suctioning equipment was set up/connected at bedside ready for use. 3. The facility failed to ensure Resident #57's O2 saturation levels were monitored in percentage as ordered. These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. The findings included: 1. Record review of Resident #36's Admission Record dated 03/13/24 documented a [AGE] year-old female, on hospice, initially admitted on [DATE], readmitted on [DATE], with the diagnoses that included epilepsy with status epilepticus (A seizure that lasts longer than 5 minutes, or having more than 1 seizure within a 5 minute period, without returning to a normal level of consciousness between episodes), respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues in your body), tracheostomy (an opening surgically created through the neck into the trachea, windpipe, to allow air to fill the lungs), intracranial injury with loss of consciousness of unspecified duration, amputation at level between right hip and knee, cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), atherosclerosis (the deposit of plaques of fatty material on the inner walls of arteries), hypertension (high blood pressure), acquired absence of right leg below knee, functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord), amputation of right leg below the knee, gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of left hand, right hand, left wrist, right wrist, left knee. Record review of Resident #36's Admission Minimum Data Set assessment dated [DATE] revealed Resident #36 had unclear speech, rarely/never understood others, rarely/never was understood by others, BIMS score of 03, indicating severe cognitive impairment, and was always incontinent of bowel and bladder. Record review of Resident #36's comprehensive care plan dated 01/04/24 revealed: FOCUS: Resident #36 had oxygen therapy Date Initiated: 01/21/2021 Revision on: 01/21/2021 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	GOALS: o The resident will have no s/sx of poor oxygen absorption through the review date. Date Initiated: 01/21/2021 Target Date: 04/03/2024 INTERVENTIONS/TASKS: OXYGEN SETTINGS: O2 via trach collar @ 5 LPM Date Initiated: 01/21/2021 Revision on: 01/21/2021. FOCUS: Resident #36 had a tracheostomy Date Initiated: 01/21/2021 Revision on: 01/21/2021 GOALS: o The resident will have clear and equal breath sounds bilaterally through the review date. Date Initiated: 01/21/2021 Target Date: 04/03/2024 o The resident will have no abnormal drainage around trach site through the review date. Date Initiated: 01/21/2021 Target Date: 04/03/2024 INTERVENTIONS/TASKS: OXYGEN SETTINGS: O2 via Trach collar @ 5 LPM Date Initiated: 01/21/2021 Revision on: 01/21/2021 Record review of physician's order dated 01/14/21 revealed: Order Summary: O2 @5LPM VIA ANSO TRACHE COLLAR (type of tracheostomy collar) every shift for ACUTE RESPIRATORY FAILURE Observation on 03/11/24 at 10:00 a.m. revealed Resident #36 was lying in bed with head of bed inclined. O2 set at 4.5 Lpm via trach. Suction canister not hooked up. Suction equipment sitting clean at bedside. Observation on 03/13/24 at 02:37 p.m., Resident #36 lying in bed with head of bed inclined. O2 set on 4.5 Lpm. Suction canister not hooked up. Suction equipment sitting clean at bedside. In an interview on 03/13/24 at 02:55 p.m., RN C went to Resident #36's room. RN C confirmed Resident #36's O2 was set on 4.5 Lpm when it should have been set on 5 Lpm. RN C stated O2 machine settings should be checked at the beginning of every shift. RN C stated she was PRN working at the facility and worked there about once a month. RN C stated today (03/13/24) was her once-a-month day PRN at the facility. RN C stated the ball (on the O2 machine meter) should be read at the top (of the ball) for the O2 setting. RN C stated the suction canister should be set up at all times in case of emergency. RN C stated they must have changed the suction canister out and did not set it up. In an interview on 03/13/24 at 03:06 p.m., LVN B, day shift nurse for Resident #36, stated she checked O2 settings for residents throughout the whole day. LVN B stated for the ball meter on the oxygen machine, the liters were to be set to the middle of the ball. LVN B stated Resident #36's O2 order was for 5 Lpm. LVN B stated at 01:30-01:40 p.m., (03/13/24), she checked the Lpm on the O2 for Resident #36, and it was set at 5 Lpm. She said RN C was with her and could verify. LVN B stated she did not know if anyone had gone in the room to change the setting. LVN B verified O2 setting was less than 5 Lpm. LVN B stated resident's oxygen saturation could drop if the O2 was not set per the physician's order. LVN B stated she checked O2 saturations every shift. LVN B stated during nebulizer treatment, they documented all vital signs including O2 saturation. LVN stated the canister equipment was on the bedside table, but was not set up ready to go because Resident #36 never needed to be suctioned. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 03/13/24 at 05:17 p.m., RT F stated she had to suction Resident #36. RT F stated the canister was supposed to be connected and ready to go at all times. RT F stated if the doctor's order was for 5 Lpm, the O2 should have been set on 5 Lpm. RT F stated if the O2 was set lower, there would be a possibility of resident desatting (low blood oxygen). In an interview on 03/13/24 at 06:36 p.m., ADON RN E (DON was on vacation) stated the O2 ball meter was read to the middle of the ball (to read an oxygen flow meter ball, the ball flow meter measurements should be taken from the middle of the ball) to set the flow rate in liters. ADON RN E stated if the O2 was less than ordered, the oxygen saturation would go down. ADON RN E stated at the worst, the resident could experience respiratory distress. ADON RN E stated the oxygen machines were to be checked every shift and as needed. ADON RN E stated as for the canister for suctioning a resident with a trach, the canister had to be set up, connected, and ready to go. ADON RN E stated it was not ok for it to be sitting there not connected. ADON RN E stated with the canister not being connected and ready to go, the resident could go into respiratory distress and they would not be ready (to suction the resident's airway). ADON RN E stated nurses were in-serviced at least once when new nurses and they were reminded all the time of trach care. 2. Review of Resident #57's Admission Record dated 03/13/24 documented a [AGE] year-old female, on hospice, initially admitted on [DATE], with the diagnoses that included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), type 2 diabetes mellitus with hyperglycemia (occurs when a person's blood sugar elevates to potentially dangerous levels), chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), hypertension (high blood pressure), parkinsonism (a disorder of the central nervous system that affects movement, often including tremors), and bipolar II disorder (characterized by depressive and hypomanic episodes). Record review of Resident #57's Quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #57 had unclear speech, usually understood others, usually was understood by others, BIMS score of 05, indicating severe cognitive impairment, and was always incontinent of bowel and bladder. Record review of Resident #57's comprehensive care plan dated 12/28/23 revealed: FOCUS: Resident #57 has c/o COUGH/CONGESTION at times INTERVENTIONS/TASKS: Monitor o2 sats as ordered FOCUS: Resident #57 has OXYGEN therapy GOALS: o The resident will have no s/sx of poor oxygen absorption through the review date. INTERVENTIONS/TASKS: o Check O2 saturation levels as ordered o Monitor for s/sx of respiratory distress and report to MD/Hospice PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. o OXYGEN SETTINGS: O2 via nasal cannula @ 2LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Physician's Order dated 04/20/23 revealed: Oxygen Saturation - Check (frequency): MAINTAIN O2 ABOVE 92% every shift for hypoxia (a state in which oxygen is not available in sufficient amounts at the tissue level) Record review of Physician's Order dated 01/29/24 revealed: Oxygen Saturation - Check every shift every shift for hypoxia Record review of Resident #57's Weights and Vitals O2 Sat Summary from PCC revealed the following documentation: 12/26/2023 02:51 a.m. 98.0% @ 2 L/Min 01/08/2024 11:34 a.m. 98.0 % Oxygen via Nasal Cannula 02/08/2024 10:31 a.m. 97.0% Room Air 03/08/2024 01:36 p.m. 96.0% Oxygen via Nasal Cannula 03/12/2024 12:29 p.m. 94.0% Oxygen via Nasal Cannula Record review of Resident #57's March 2024 MAR/TAR revealed check marks only for the above orders. There were not oxygen saturation percentages on the March 2024 MAR/TAR for any shift on any day. There were check off marks only. In an interview on 03/12/24 at 03:20 p.m., ADON LVN D stated if there was an order for O2 saturations to be checked every shift or as needed, it (O2 saturations) would be documented under weights and vitals in PCC, and a percentage would be put in. ADON LVN D stated if the percentage was not put in the computer, the resident could desat, and no one would know the resident was desatting which would not be good for the resident. In an interview on 03/13/24 at 03:06 p.m., LVN B stated resident's oxygen saturation could drop if the O2 was not set per the physician's order. LVN B stated she checked O2 saturations every shift. LVN stated they documented all vital signs including O2 saturation on PCC either on the MAR/TAR or Weights & Vitals. In a telephone interview on 03/13/24 at 05:17 p.m., RT F stated if the doctor ordered monitoring of the O2 saturation, O2 saturation should be documented in percentage because that is how it is read, in percentage. RT F stated if the O2 saturation was not documented in percentage, how would they know if the resident was desatting. RT F stated O2 sats were always in percentages. In an interview on 03/13/24 at 06:36 p.m., ADON RN E stated that if there were an order to monitor O2 sats, it would be documented in the MAR and also in Weights and Vitals in PCC. ADON RN E stated if O2 saturations were not documented in percentage, they would not know the baseline. ADON RN E stated O2 sats were always in percentages. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Oxygen - policy and procedures was requested. Facility copied pages out of Lippincott's Manual to give to surveyor. No policies were given.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 26920 Based on interview and record review the facility failed to ensure the physician acted upon and documented his or her rationale in the resident's medical record to the pharmacist report of any irregularities for 3 of 8 Residents (Resident #35, Resident #58, and Resident #87) whose records were reviewed for pharmacy services. 1.The facility failed to ensure the physician provided a rationale in response to the pharmacist recommendation to evaluate the effectiveness and continued use of Lorazepam (anti-anxiety), Hydroxyzine (antihistamine used to treat itching, anxiety, or sleepiness), and Clonazepam (treatment for seizures and panic disorder) for Resident #35. 2.The facility failed to ensure the physician provided a rationale in response to the pharmacist recommendation to evaluate the effectiveness and continued use of Omeprazole (treatment of gastroesophageal reflux disease) for Resident #58. 3.The facility failed to ensure the physician provided a rationale in response to the pharmacist recommendation to evaluate the effectiveness and continued use of Lithium (anti-psychotic and treatment for bipolar disease and major depressive disorder,) and Zyprexa (anti-psychotic , used to treat schizophrenia and bipolar disorder) for Resident # 87. This deficient practice could affect any resident and could result in resident's receiving psychotropic medications longer than required. The findings were: 1.Record review of the physician order summary dated 03/13/24 for Resident #35 reflected resident was admitted on [DATE], was a [AGE] year-old female with diagnosis which included convulsions (a sudden, violent irregular movement), functional quadriplegia (loss of motor and/or sensory function), delusion disorders (mental illness, paranoia), tremors, anxiety (unpleasant state of inner turmoil), diabetes (high blood sugar levels), major depressive disorder and was under hospice care. Orders included. -Clonazepam , 0.25 mg give one tablet by mouth two times a day for anxiety, start date 07/22/23. -hydroxyzine HCl oral tablet 50 mg, give 2 tablets by mouth three times a day for anxiety, start date 07/19/23. -Lorazepam oral concentrate 2 mg/ml. give 0.5 ml by mouth every 4 hours as needed for anxiety, start date 01/01/24. No stop date was indicated. Record review of the significant change MDS assessment dated [DATE] for Resident # 35 reflected. -BIMS score was 08 (cognitive status was moderately impaired , decisions poor; cues/supervision required,) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-received anti-anxiety diuretic and opioid medications in the last seven days. Record review of comprehensive care plans dated 10/19/23 for Resident #35 reflected resident used anxiety medications and interventions included. -administer medications as ordered. -monitor behavior episodes PRN and attempt to determine underlying cause. -monitor the resident for safety. Record review of the physician communications form dated 02/28/24 for Resident #35 reflected the pharmacist consultant recommended CMS Mega Rule Phase II-PRN orders for psychotropic drugs are limited to14 days, except if the prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. Prescriber should document the rationale in the resident's medical record and indicated the duration for the PRN order. Current medication: Lorazepam PRN anxiety. The recommendation rationale from hospice physician was not obtained until 03/13/24 after surveyor intervention. The response indicated to continue with the PRN order for 14 days. Record review of the physician communications form dated 01/30/24 for Resident #35 reflected the pharmacist consultant recommended anxiolytic gradual dose reduction attempt for Clonazepam 0.25 mg bid and Hydroxyzine 100 mg tid. All agents following within the psychoactive category (without regard to indication) fall under gradual dose reduction guidelines. This includes agents within the anxiolytic category. Please address the appropriate response below. The pharmacist consultant recommendation was signed by the hospice physician on 03/13/24 after surveyor intervention. The physician's response was an attempted GDR is likely to result in impairment of function or increased decreased behavior. 2.Record review of the physician order summary dated 03/31/24 for Resident #58 reflected Resident #38 was admitted on [DATE], was a [AGE] year-old male with diagnosis that included diabetes (sustained high blood sugar levels) , heart failure, gastro-esophageal reflux disease without esophagitis (digestive disorder), and anxiety. An order for Prilosec OTC (omeprazole) tablet delayed, give one tablet by mouth one time a day related to gastro-esophageal reflux disease, start date 11/21/23. Record review of the quarterly MDS dated [DATE] for Resident #58 reflected his BMIS score was 15 (cognitive status was independent (decisions consistent/reasonable). Record review of the comprehensive care plans dated for Resident 35 reflected resident had GERD, dated 04/04/22. Interventions included to give medications as ordered. Monitor and document side effects and effectiveness PRN, dated 04/04/22 and obtain and monitor lab/diagnostic work as ordered, report results to MD and follow up as indicated. Record review of the comprehensive care plan dated 04/04/22 for Resident #58 reflected resident had GERD. Interventions included to monitor vital signs as ordered, PRN and notify MD of significant abnormalities. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the physician communications form dated 01/30/24 for Resident #58 reflected the pharmacist consultant recommendation Omeprazole 20 mg daily for GERD since 11/21/23. The recommended duration based on the indications for PPIs is 4-8 weeks per product labeling and CMS. Long term use has been associated with increased risk of C. Diff Colitis, CAP, and B12 deficiency. The pharmacist consultant recommendation was responded on 03/13/24 by Resident #58's physician to discontinue medication and add Famotidine 20mg BID, PRN for indigestion and heartburn. 3.Record review of the physician order summary dated 03/31/24 for Resident #87 reflected Resident #87 was admitted on [DATE], was a [AGE] year-old female with diagnosis that included anxiety disorder (uncontrollable feelings of anxiety), diabetes (high blood sugar levels), chronic kidney disease (gradual loss of kidney functions), major depressive disorder (causes persistent sadness), bipolar disorder (causes extreme moods), and insomnia (sleeplessness). An order for Lithium carbonate ER oral tablet extended release 450 mg, give one tablet by mouth one time a day for bipolar disorder, start date 02/21/24. An order for Zyprexa oral tablet 5 mg (olanzapine),give 2 tablets by mouth two times a day for anxiety, start date 03/09/24. Record review of the quarterly MDS dated [DATE] for Resident #87 reflected. -BMIS score was 15 (cognitive status was independent (decisions consistent/reasonable). -received antipsychotic, antidepressant, antibiotic, insulin medications in the last seven days. -gradual dose reduction had not been attempted. Record review of the comprehensive care plans dated for Resident #87 reflected resident used anti-psychotic medications related to bipolar disorder, date initiated 07/07/23. Interventions included monitoring for lithium toxicity is closely related to serum lithium levels and can occur at doses close to therapeutic levels, follow up for prompt and accurate serum lithium determinations should be available before initiating therapy. Resident used antipsychotic medication related to bipolar disorder, date initiated 07/07/23. Interventions included to administer medications as ordered per MD, dated 07/07/23 and monitor/document/report PRN any adverse reactions of antipsychotic medications and pharmacy consultant to review medications at least monthly, dated 07/07/23. Record review of the physician communications form dated 02/28/24 for Resident #87 reflected. Resident currently receives an antipsychotic; Lithium ER 450mg daily for bipolar and Zyprexa 5 mg bid for anxiety. Please review the continued use of this antipsychotic. The pharmacist consultant recommendations had not been addressed by the resident's physician and documented 3/13/24; pending call back from doctor. Interview on 03/13/24 at 9:25 am with ADON/LVN D revealed LVN R was responsible to call the doctors for all pharmacy consultant recommendations and she was currently out on leave. ADON/LVN D said Medical Records Q would get the recommendations from LVN R after she had obtained a response from the doctors. Medical Records Q would download the completed pharmacy consultant recommendations in each resident's clinical chart. (continued on next page)

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	676037	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weslaco Nursing and Rehabilitation Center	422 E 18th St Weslaco, TX 78596

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/13/24 at 2:02 pm with ADON/LVN D revealed the pharmacy consultant recommendations for Resident #35, Resident #58 and Resident #87 had not been completed with the response by their respective doctors. ADON/LVN D said she was not sure why they had not been completed. Interview on 03/13/24 at 2:55 pm with the Pharmacy Consultant revealed he expected the facility to contact the respective physicians for Resident #35, Resident #58, and Resident #87 in a timely manner. Each resident had different recommendations, but they should have been responded by their doctors as soon as possible. Interview on 03/14/24 at 11:49 am with ADON/RN E revealed the pharmacy consultant recommendations should have been addressed and acted on as soon as the doctor was called and contacted. A follow up to get the response from the physicians should be made as soon as possible. ADON/RN E said the DON who was on leave, was responsible to ensure the staff were getting the responses from the doctors as soon as possible. ADON/RN said the failure to obtain a response for the recommendations could have had adverse effects on the medication administration of each medication for Resident #35, Resident #58, and Resident #87. Record review of the facility policy's titled Consultant Pharmacist Services and Reports dated 10/01/19 reflected The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and/or responsibility to implement the recommendations and responded to in an appropriate and timely fashion. Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation directed to him/her within 30 days, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26920 Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed, and documented, that it was appropriate for the PRN order to be extended beyond 14 days for one of eight residents (Resident #35) reviewed in that. The facility to continue to administer the psychotropic medication Lorazepam 0.5mg PRN after 14 days without an evaluation by the physician for continued treatment. This failure could result in residents receiving psychotropics that placed residents at risk of experiencing adverse drug reactions. The findings include: Record review of the physician order summary dated 03/13/24 for Resident #35 reflected resident was admitted on [DATE], was a [AGE] year-old female with diagnosis which included convulsions (a sudden, violent irregular movement), functional quadriplegia (loss of motor and/or sensory function), delusion disorders (mental illness, paranoia), tremors, anxiety (unpleasant state of inner turmoil), diabetes (high blood sugar levels), major depressive disorder and was under hospice care. An order for Lorazepam oral concentrate 2 mg/ml. give 0.5 ml by mouth every 4 hours as needed for anxiety, start date 01/01/24. No stop date was indicated. Record review of the MARs dated January 2024, February 2024 and March 2024 reflected Resident #35 received the medication Lorazepam PRN on 01/01/24 01/02/24 01/03/24 01/15/24 01/16/24 01/20/24 01/30/24 02/02/24 02/03/24 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/09/24 02/11/24 02/18/24. No medication was administered in the month of March 2024. Record review of the significant change MDS assessment dated [DATE] for Resident # 35 reflected. -BIMS score was 08 (cognitive status was moderately impaired , decisions poor; cues/supervision required,) -received anti-anxiety diuretic and opioid medications in the last seven days. Record review of comprehensive care plans dated 10/19/23 for Resident #35 reflected resident used anxiety medications and interventions included. -administer medications as ordered. -monitor behavior episodes PRN and attempt to determine underlying cause. -monitor the resident for safety. Record review of the physician communications form dated 02/28/24 for Resident #35 reflected the pharmacist consultant recommended CMS Mega Rule Phase II-PRN orders for psychotropic drugs are limited to14 days, except if the prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. Prescriber should document the rationale in the resident's medical record and indicated the duration for the PRN order. Current medication: Lorazepam PRN anxiety. The recommendation rationale from hospice physician was not obtained until 03/13/24 after surveyor intervention. The response indicated to continue with the PRN order for 14 days. Interview on 03/13/24 at 9:25 am with ADON/LVN D revealed LVN R was responsible to call the doctors for all pharmacy consultant recommendations and she was currently out on leave. ADON/LVN D said Medical Records Q would get the recommendations from LVN R after she had obtained a response from the doctors. Interview on 03/13/24 at 2:02 pm with ADON/LVN D revealed the pharmacy consultant recommendations for Resident #35 had not been completed with the response by their respective doctors. ADON/LVN D said she was not sure why they had not been completed. The order for medication Lorazepam was PRN and did not have a stop date as it was required. Interview on 03/13/24 at 2:55 pm with the Pharmacy Consultant revealed he had recommended a stop date for Lorazepam and had expected the facility to contact the respective physicians for Resident #35 in a timely manner to review the order for a psychotropic medication Lorazepam. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/14/24 at 11:49 am with ADON/RN E revealed the pharmacy consultant recommendation for Resident #35 should have been addressed and acted on as soon as the doctor was called and contacted. ADON/RN said the failure to obtain a response for the recommendation could have had adverse effects on the medication administration of the PRN medication, Lorazepam for Resident #35. Record review of the facility policy titled Psychotropic Medication dated 08/15/22 reflected Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication (s). PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration, (i.e.) 14 days.

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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** 26920 Based on observations, interviews and record review the facility failed to ensure medications and biologicals were stored in locked compartments for one of eight residents (Resident # 50) reviewed for medication storage. The facility failed [NAME] prevent Resident #50 from having medication at his bedside for his personal use. This failure placed residents at risk of accidental and adverse medication reactions. Findings included: Record review of Resident #50's admission record dated 0/13/24 reflected Resident # 50 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cirrhosis of liver (scarring of the liver by chronic liver diseases), and diabetes (sustained high sugar levels.) Record review of Resident #50's quarterly MDS assessment dated [DATE], reflected a BIMS score of 10 out of 15 which indicated moderately cognitive impairment (decisions poor; cues/supervision required.) Record review of Resident #50's comprehensive care plans dated 01/18/24, reflected focus area, has an ADL self-care performance deficit r/t CVA effects impaired balance/coordination, and cognitive deficits. Interventions included skin inspection; the resident requires skin inspection with care and PRN, observe for redness, open areas , scratches , cuts, bruises and report changes to the nurse, revised on 10/04/22. Resident #50's care plans reflected no evidence resident would self-medicate. Record review of Resident #50's physician orders dated 03/12/24, revealed no physician's order to self-administer medications. During an observation on 03/11/24 at 10:50 am, Resident #50 was observed sitting on his bed. A tube of medication Gelmicin, (anti-fungal, antimicrobial, and anti-inflammatory), 40 mg (tube cream) was observed on top of his overbed table. The medication tube was approximately full. The medication administration on the tube indicated 0.5 mg. Interview on 03/11/24 at 10:55 am with Resident #50 revealed he used the medication Gelmicin for itching on his arms and legs. Resident #50 said FM J brought his medication from Mexico because he wanted to use that medication for his itching. Resident #50 said he did not know if any other skin cream was applied by staff for his itching skin. Resident #50 said staff were aware that he used the cream for his itching skin. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/24 at 11:06 am with CNA G revealed she knew that Resident #50's FM J brought him the medication Gelmicin, from Mexico because he liked to use for his itching skin in his arms and legs. CNA G said she had not reported this incident to the charge nurse because she thought he already knew about this medication that the resident kept in his cabinet drawer. Resident #50 had been using the medication for some time. Interview on 03/11/24 at 1:57 pm with LVN H revealed FM J would bring in Gelmicin medication for the resident to use for his skin itching. LVN H said he had spoken to FM J several times that resident could not have the medication for personal use unless it was prescribed by his physician. LVN H said he had called Resident #50's physician so he could order a similar medicine for skin itching but the doctor had not responded to the request. LVN H said he had informed the DON and MDS/LVN I but no one had addressed it. LVN H said the medication Gelmicin was not care planned. He said he had removed the medication from Resident #50's personal possession several times but FM J kept bringing the medication back to the resident. Interview on 03/12/24 at 3:20 pm with ADON/LVN D revealed residents were not allowed to keep their own medications unless they were permitted by a doctor's order. ADON/LVN D said Resident #50 did not have an order to self-administer any medication. ADON/LVN D said they educated family members to inform the staff if they brought in medications for residents. ADON/LVN D said she had not seen any documentation in Resident #50's clinical chart that FM J was bringing in some medications for him or that staff had knowledge that Resident #50 had a medication for his personal use. Interview on 03/12/24 at 3:30 pm with LVN H revealed he had not documented any notes or information that Resident #50 had FM J bring in a medication to use for his skin itching or that he had called Resident #50's physician to prescribe another medication for the skin itching for Resident #50. LVN H said he had called Resident #50's physician on 03/12/24 to ask for a medication for skin itching for Resident #50 and his physician gave orders for ammonium lactate to treat dry skin for the itching. LVN H said he had removed Resident #50's Gelmicin medication yesterday and FM J had called him and asked if he could return the medication back to Resident #50. LVN H told FM J she could not continue to bring in the medication. LVN H said he had obtained orders for another medication for the dry skin and itching. Record review of a change of condition form dated 03/11/24 at 5:58 pm completed by LVN H for Resident #50 reflected a change in condition due to resident complaining of skin dryness to bilateral arms and legs and indicated the condition had not occurred before. Additional notes in the change of condition form reflected resident noted with dryness, reports itching to bilateral arms and legs. Notified doctor and received new order for ammonium lactate daily for dry skin. Interview on 03/13/24 at 2:06 pm with ADON/LVN D revealed the failure to address medications that were brought in for personal use by residents placed residents at risk at risk for an allergic reaction, depending on types of medications. ADON/LVN D said staff should have documented in resident's clinical charts the incident that Resident #50 had medications for his personal use and notify the DON. LVN H had not documented any notes in Resident #50's clinical chart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/14/24 at 11:40 am with ADON/RN E revealed residents were not allowed to keep medications in their rooms. Staff should contact the resident's physician to obtain orders for a medication that can be made available. ADON/RN E said she was not aware of Resident #50's use of his personal medication Gelmicin that FM J had brought to Resident #50. LVN H had not mentioned this incident to anyone else. LVN H should have informed the DON and documented on his nurse's notes. LVN H should have assessed Resident #50 and obtained medications from his physician. ADON/RN E said staff were required to do rounds and look for medications in resident's possession. Record review of the facility's policy titled Medication Administration dated 10/01/19 reflected. Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare medications. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards or food service safety for 1 of 1 kitchen reviewed for sanitation in that: The facility failed to remove 27 gallons of water that were past the use by date from their emergency drinking water supply. This failure could place residents at risk of foodborne illnesses. The findings included: In an observation of the kitchen on [DATE] beginning at 9:10 a.m., revealed there were 27 gallons of water dated [DATE] and a use by date of [DATE] stored in the back of the kitchen where the emergency water supply was stored. An interview on [DATE] at 9:30 a.m., the Dietary Manage said the current emergency water supply had been there prior to her being hired. The Dietary Manager said she would remove the expired water gallons immediately and replace them with new ones. The Dietary Manger did not say if resident's could be negatively affected by drinking water past the use by date. An interview on [DATE] at 4:30 p.m., the Administrator said he would make sure the expired water gallons were removed and replaced as soon as possible. Record review of facility's Emergency and Disaster Planning dated [DATE] and revised on [DATE] revealed: Policy: The facility is committed to ensuring that it's residents, staff and any incoming residents from other facilities are provided with adequate nutrition during emergencies or natural disasters. Water: Emergency water supplies must be stored under sanitary conditions and must meet the following criteria: a. The containers of drinking water must be dated and not expired.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26920 Based on observation, interview and record review the facility failed to maintain clinical records that were complete and/or accurate for one of eight (Resident #50) residents reviewed for clinical records in that: The facility failed to document in Resident #50's clinical chart that Resident #50 had family bring in medications for his personal use. This failure could place residents at risk of not having accurate medical records and could create confusion in services provided or needed to be provided. Finding included: Record review of Resident #50's admission record dated 0/13/24 reflected Resident # 50 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cirrhosis of liver (scarring of the liver by chronic liver diseases), and diabetes (sustained high sugar levels.) Record review of Resident #50's quarterly MDS assessment dated [DATE], reflected a BIMS score of 10 out of 15 which indicated moderately cognitive impairment (decisions poor; cues/supervision required.) Record review of Resident #50's comprehensive care plans dated 01/18/24, reflected focus area, has an ADL self-care performance deficit r/t CVA effects impaired balance/coordination, and cognitive deficits. Interventions included skin inspection; the resident requires skin inspection with care and PRN, observe for redness, open areas , scratches , cuts, bruises and report changes to the nurse, revised on 10/04/22. Resident #50's care plans reflected no evidence resident would self-medicate. Record review of Resident #50's physician orders dated 03/12/24, revealed no physician's order to self-administer medications. During an observation on 03/11/24 at 10:50 am, Resident #50 was observed sitting on his bed. A tube of medication Gelmicin, (anti-fungal, antimicrobial, and anti-inflammatory), 40 mg (tube cream) was observed on top of his overbed table. The medication tube was approximately full. The medication administration on the tube indicated 0.5 mg. Interview on 03/11/24 at 10:55 am with Resident #50 revealed he used the medication Gelmicin for itching on his arms and legs. Resident #50 said his FM J brought his medication from Mexico because he wanted to use that medication for his itching. Resident #50 said he did not know if any other skin cream was applied by staff for his itching skin. Resident #50 said staff were aware that he used the cream for his itching skin. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/24 at 11:06 am with CNA G revealed she knew that FM J brought him the medication Gelmicin, from Mexico because he liked to use for his itching skin in his arms and legs. CNA G said she had not reported this incident to the charge nurse because she thought he already knew about this medication that the resident kept in his cabinet drawer. Resident #50 had been using the medication for some time. Interview on 03/11/24 at 1:57 pm with LVN H revealed FM J would bring in Gelmicin medication for the resident to use for his skin itching. LVN H said he had spoken to FM J several times that resident could not have the medication for personal use unless it was prescribed by his physician. LVN H said he had called Resident #50's physician so he could order a similar medicine for skin itching but the doctor had not responded to the request. LVN H said he had informed the DON and MDS/LVN I but no one had addressed it. He said he had removed the medication from Resident #50's personal possession several times but FM J kept bringing the medication back to the resident. Interview on 03/12/24 at 3:20 pm with ADON/LVN D revealed residents were not allowed to keep their own medications unless they were permitted by a doctor's order. ADON/LVN D said Resident #50 did not have an order to self-administer any medication. ADON/LVN D said they educated family members to inform the staff if they brought in medications for residents. ADON/LVN D said she had not seen any documentation in Resident #50's clinical chart that FM J was bringing in some medications for him or that staff had knowledge that Resident #50 had a medication for his personal use. Interview on 03/12/24 at 3:30 pm with LVN H revealed he had not documented any notes or information that FM J bring in a medication to use for his skin itching or that he had called Resident #50's physician to prescribe another medication for the skin itching for Resident #50. LVN H said he had called Resident #50's physician on 03/12/24 to ask for a medication for skin itching for Resident #50 and his physician gave orders for ammonium lactate to treat dry skin for the itching. LVN H said he had removed Resident #50's Gelmicin medication yesterday and FM J had called him and asked if he could return the medication back to Resident #50. LVN H told FM J she could not continue to bring in the medication. LVN H said he had obtained orders for another medication for the dry skin and itching. Record review of a change of condition form dated 03/11/24 at 5:58 pm completed by LVN H for Resident #50 reflected a change in condition due to resident complaining of skin dryness to bilateral arms and legs and indicated the condition had not occurred before. Additional notes in the change of condition form reflected resident noted with dryness, reports itching to bilateral arms and legs. Notified doctor and received new order for ammonium lactate daily for dry skin. Interview on 03/13/24 at 2:06 pm with ADON/LVN D revealed that failure to address medications that were brought in for personal use by residents placed residents at risk at risk for an allergic reaction, depending on types of medications. ADON/LVN D said staff should have documented in resident's clinical charts the incident that Resident #50 had medications for his personal use and notify the DON. LVN H had not documented any notes in Resident #50's clinical chart. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/14/24 at 11:40 am with ADON/RN E revealed residents were not allowed to keep medications in their rooms. Staff should contact the resident's physician to obtain orders for a medication that can be made available. ADON/RN E said she was not aware of Resident #50's use of his personal medication Gelmicin that FM J had brought to Resident #50. LVN H had not mentioned this incident anyone else. LVN H should have informed the DON and documented on his nurse's notes. LVN H should have assessed Resident #50 and obtained medications from his physician. ADON/RN E said staff were required to do rounds and look for medications in resident's possession. Record review of the facility's policy titled Documentation in Medical Record dated 10/24/22 reflected Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided.