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	05/14/2025

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** 48278 Based on interview and record review, the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #262) of 8 residents reviewed for Advance Directives. The facility failed to ensure Resident #262's OOH-DNR was completed. The OOH-DNR form did not have the physician's signature. This failure could affect all residents who have implemented Advance Directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes. The findings were: Record review of Resident #262's electronic face sheet dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included Syncope (fainting) and Collapse, Hypertensive urgency (high blood pressure), Nonrheumatic Mitral Valve Disorder (mitral valve does not close properly, allowing blood to flow backwards into the heart), Atrioventricular Block first degree (a condition where the hearts wiring was slow to send electrical signals), Paroxysmal Atrial Fibrillation (episodes of irregular heartbeat), and Somnolence (a state of drowsiness or strong desire to fall asleep). Record review of Resident #262's BIMS dated [DATE],5 revealed she scored a 15, which indicated she was cognitively intact. Record review of Resident #262's care plan revealed, Resident #262 was a DNR. Interventions: Ensure signed DNR was in medical record. If resident has a cardiac arrest, do not call 911 or initiate CPR. Notify MD/RP and follow instructions after notification. Keep resident as comfortable as possible at all times. [NAME] chart and all pertinent documents with DNR status. Send copy of DNR paperwork upon transfer from facility. Social services consult if resident/family want to change code status. Record review of Resident #262's physician order dated [DATE] revealed, DNR (Do Not Resuscitate). (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 #262's OOH-DNR form dated [DATE] revealed the form was signed in section A. Declaration of the adult person: I am competent and at least [AGE] years of age. I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardia pacing, defibrillation, advanced airway management, artificial ventilation. The OOH-DNR revealed the form was not signed by the attending physician in section: Physician's Statement: I am the attending physician of the above noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in our-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation. It also revealed the physician did not sign below in the last section All persons who have signed above must sign below, acknowledging that this document has been properly completed. In an interview on [DATE] at 10:44 a.m. with SS, she stated upon admission when doing the initial social history, she informed the resident and/or family of their rights regarding the DNR. She explained the difference between DNR and full code. She explained the risks involved when receiving CPR. If it were requested for the resident to be a DNR, she provided them with the form, and obtained their signatures. SS stated that she has been trained to have DNR form completed within 24 hours. She stated the DNR form was placed in a binder at the nurse's station, even if form was incomplete, missing MD signature. She puts the original DNR form in the MD binder and shares it with medical records. Medical Records, who was responsible to get the form signed by the physician. SS stated the form was not complete until the physician signs it. In an interview on [DATE] at 11:02 a.m. with MR, she stated that she scans the DNR form sand emails them to the physician to get it signed. She stated that she tries to get it signed within 24 hours. She stated if the resident was a new admit, she would not leave without uploading the form and sending it to the physician. MR stated she will then take the form to social services, and she puts it in the binder. She stated the DNR form was not complete until the physician signs. MR stated that it was important for the physician to sign the DNR form because if staff does not know that they were DNR and they do CPR, the family would be upset. She verified that the DNR form for Resident #262 was missing the physician signature. She checked her email and did not find anything. MR stated that she was out on [DATE] and the social worker put it in the binder, uploaded it and sent it out to the physician. MR stated she will email the physician right now. In an interview on [DATE] at 11:20 a.m. LVN F, stated that he was Resident #262's nurse. He stated that he could not remember at the top of his head what her code status was, but he would check in PCC. He located Resident #262's in PCC and stated that she was a DNR. He stated that the person responsible for the DNR form to be completed was the social worker. She takes care of asking the families and patients. He stated the DNR form was considered complete when the following signatures were on the form- the patient, the family member, 2 witnesses, and the MD. He stated if the DNR was not signed by the MD that, they can call and get a verbal order. He stated the purpose of the DNR form was to make sure what codes status or whishes the patient chooses in case they code. He stated the DNR code status was located in PCC and in the DNR binder. He stated if the patient does not have a DNR in place, then they were considered a full code. (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 11:30 a.m. with the DON, she stated the DNR form was done upon admission and the social worker also completes the form. The patient and the family will decide if full code or DNR. She stated if the patient was nonverbal then we do full code until the patient's family tells us otherwise. The facility obtains the patient or RP to signature, witnesses and we contact MD. She stated that if DNR form was not signed by MD then it was considered incomplete, but they do honor the patient's wishes since they have the MD order. The DON stated that the MD does not come in daily, and it was impossible to get for signed the same day. She stated that they try to get the MD signature on the DNR form as soon as possible in case the patient goes out to the hospital. If they don't have an MD signature on the DNR form, then the staff will have to call the hospital nurse and inform them that it has not been signed. She stated that there was no timeframe to get the MD signature on the DNR form. She stated that the nurse puts the code status in PCC. The DON stated that as soon as the RP or patient signs form that they change code status in the PCC even if MD has not signed. They get a verbal order; he just hasn't signed the DNR form. Medical records have been told not to take too long to get them signed. The DON provided me with a copy of the DNR at 1:56 p.m. , and it revealed the MD signed it today, [DATE]. In an interview on [DATE] at 5:50 p.m. with the ADM, stated that the DNR forms were discussed in their morning meetings. She stated that this was the first thing social services tries to get in motion during new admissions. They also conduct self-audits. She stated that as soon as the DNR forms come in, they get MD signature, or they get a verbal order. They try to have medical records run to their medical office to obtain signatures. She stated that in order for the DNR form to be completed it would have to have all three signatures. ADM stated she was not familiar with the DNR form policy, but social services would be better with the DNR form policy questions. She stated that between medical records and social services, they work on getting MD signatures on the DNR forms. Record review of the facility's Residents' Rights Regarding Treatment and Advance Directives policy dated [DATE], revealed the following: Policy: It is the policy of this facility to support and facilitate a residents right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Definitions: Advance directive is a written instruction, such as a living will or durable power of attorney for heal care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the induvial is incapacitated. Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed and advance directive, and if not, determine whether the resident would like to formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart . Record review of the OOH DNR Order instructions for issuing and OOH-DNR Order revealed the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. Applicability: This OOH-DNR Order applies to health care professions in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments. Implementation: A competent adult person at least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows: In addition: the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making and OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section.

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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** 49301 Based on interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #40) of 8 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #40 was coded in the MDS for a fall on 3/30/25. This failure could place residents at risk of receiving care and services to meet their needs. The findings included: Record review of Resident #40's face sheet dated 05/18/25 reflected Resident #40 was admitted on [DATE] and was [AGE] years old. Resident #40 had diagnoses of muscle wasting and atrophy (decrease or wasting of tissue, muscle or organs), lack of coordination, abnormalities of gait (pattern walking or moving on foot) and mobility, dementia (major neurocognitive disorder which causes a progressive decline in cognitive function, such as memory, thinking, reasoning, and judgment), and Alzheimer's disease (a type of dementia/neurodegenerative disease that affects the brain causing memory loss, confusion, and changes in behavior). Record review of Incident Log reflected Resident #40 had a witnessed fall on 3/30/25. Record review of Resident #40's undated comprehensive care plan reflected: Resident #40 had an actual fall. Educated resident on importance of using call light and waiting for assistance with tall transfers and assistance with ADL on 3/30/35. Labs: UA/C&S on 3/30/25. Monitor/document/report PRN x 72h to MD for s/sx: Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation on 3/30/25. NP/RP/DON notified on 3/30/25. Record review of Resident #40's progress notes dated 3/30/35 at 6:00 pm, written by LVN H indicated a change of condition due to resident stated had a witnessed fall. It also reflected a mental status change, vitals/assessment completed, and notifications made to RP and NP. Labs and medications were ordered. Record review of Resident #40's Discharge MDS dated [DATE] revealed: Section GG130 revealed Resident #40 required partial/moderate assistance for showering/bathing and supervision or touch/setup for all other self-care and Section J1800 and J1900 revealed no falls since Admission/Entry or Reentry or Prior Assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/14/25 at 8:54 am the DON said falls were captured on the care plan by the floor nurse. She said if falls were not captured on the care plan, it could cause a lack of communication with the MDS department. They would not get the information of a resident's fall. She said they also had meetings every day to discuss any incidents, and the MDS department also obtained information on any falls at these meetings. She said the MDS department was responsible for capturing and documenting falls on the MDS assessment. The DON said it would not have any negative outcome on the resident who had a fall, because the floor nurses, ADONs, and DON will edit the care plan upon the fall and add any interventions right away and update as needed. In an interview on 5/14/25 at 3:00 pm MDS G said falls should be captured between MDS assessments. She said for Resident #40, the fall should have been captured on the discharge MDS dated [DATE] and it was not. She said the negative outcomes could be the hospital he was discharged to would not know he had a recent fall and plan interventions for the fall. She said if it had been a fall with a serious injury, they would not know what precautions to take. She said Resident #40 had a no serious injuries from his fall. Record review of CMS's RAI Version 3.0 Manual dated 10/2024, reflected section: J1800: Any falls since admission/entry or reentry or prior to assessment . Coding instructions: Code 1, yes if the resident has fallen since the last assessment. Continue to number of falls since admission/entry or reentry or prior to assessment . item (J1900), . J1900: Number of falls since admission/entry or reentry or prior assessment . Coding instructions for J1900A, No Injury: Code 1, one: if the resident had one non-injurious fall since admission/entry or reentry or prior assessment .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 50487 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 (Resident #40 and Resident #23) of 8 residents reviewed for care plans, in that: 1.The facility failed to ensure Resident #40's most current undated care plan reflected his diagnosis of dementia. 2.The facility failed to develop a comprehensive person-centered care plan to address Resident #23's antibiotics for pneumonia. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings included: 1. Record review of Resident #40's face sheet dated 05/18/25 reflected Resident #40 was admitted on [DATE] and was [AGE] years old. Resident #40 had diagnoses of muscle wasting and atrophy (decrease or wasting of tissue, muscle or organs), lack of coordination, abnormalities of gait (pattern walking or moving on foot) and mobility, dementia (major neurocognitive disorder which causes a progressive decline in cognitive function, such as memory, thinking, reasoning, and judgment), and Alzheimer's disease (a type of dementia/neurodegenerative disease that affects the brain causing memory loss, confusion, and changes in behavior). Record review of Resident #40's most recent undated comprehensive care plan did not include dementia as a diagnosis. Record review of Resident #40's quarterly MDS dated [DATE] revealed: Section I - Active Diagnoses Neurological: Non-Alzheimer's Dementia Other: Unsp Dementia, Unsp severity, without beh/psych/mood/anx (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/14/25 at 8:54 am the DON said she knew the MDS department had up to 14 days to complete the assessment. She said the MDS department updated the initial care plans from the MDS assessment, such as for dementia, smoking, etc. She said the floor nurses, ADONs, and DON will update care plans as needed for anything new that had not been addressed in the initial care plan, such as upon a fall. The floor nurses would edit the care plan with interventions right away even if there is no injury because an intervention needs to be done. She said if not on the care plan, there would be a lack of communication and interventions not done. In an interview on 5/14/25 at 3:00 pm MDS G said she was the MDS for the facility's long term care residents. She said the comprehensive care plan will be completed with active diagnosis that were on the MD note and were being treated/provided interventions. She said they usually must care plan for a diagnosis such as Dementia, unless it was not an active diagnosis - not receiving any treatments/interventions for the past 30 to 60 days and the MD did not list the diagnosis as an active diagnosis prior to the most recent MDS Assessment. She said there were no specific diagnosis that were automatically care planned. She said they would capture the active diagnosis on the MDS under active diagnosis. She said for Resident #40, the MD did not include dementia in the most recent progress notes dated 5/13/25. Surveyor asked MDS, since the most recent MDS dated [DATE] show Dementia as an active diagnosis, should dementia have been care planned at that time? MDS said dementia was only included on the MDS because as best practice, we were instructed to place all hospital discharge diagnosis on the MDS assessments. She said Resident #40 was only here for wound care and antibiotics and had a BIMS of 14, so dementia should not have been care planned as an active diagnosis. She said there was no MD support for Dementia as an active diagnosis. She said it could be looked as an oversight on the MDS department, but when they complete the next review in 60 to 90 days, they will get with the MD/NP to see which diagnosis were considered active and which could be resolved/removed. She said there would be no negative outcomes because the resident was still receiving care/interventions for his active diagnosis and his BIMS was high. She said Resident #40's MD also made frequent rounds and picked up changes right away. Record review of CMS's RAI Version 3.0 Manual dated 10/2024, reflected section: I: Active Diagnoses in the last 7 days Active Diagnoses in the last 7 days - Check all that apply . Item Rationale Health-related Quality of Life Planning for Care This section identifies active diseases and infections that drive the current plan of care. Steps for Assessment . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses. 2.Review of Resident #23's Admission Record dated 05/12/2025 revealed an admitted [DATE] and originally admitted on [DATE]. The Resident's diagnoses included Pneumonia (a serious lung infection where the air sacs (alveoli) fill with fluid or pus, causing inflammation and difficulty breathing.), Alzheimer's disease (a progressive, neurodegenerative brain disorder that primarily affects memory and thinking skills). Review of the Resident #23's Care Plan, dated 02/13/2023, revealed the care plan did not identify the resident's treatment for pneumonia. Review of Resident #23's most recent comprehensive MDS assessment dated [DATE], revealed the resident was taking an antibiotic for the last 7 days. Review of the Resident #23's physician orders dated 05/12/2025 revealed Resident #23 received Ceftriaxone sodium intravenous solution reconstituted 1 gram, administer 1 gram via intravenously one time a day for pneumonia for 5 days with a start day on 5/9/2025 and end date 5/14/2025. During an interview on 05/5/25 at 9:44 a.m. MDS G nurse stated the care plan should have been updated when and by whomever received the order for the antibiotic. MDS nurse stated if the care plan was not updated it could affect the nurses by not being able to give the care that Resident #23 needed. During an interview on 5/13/25 at 10:00 a.m. ADON C stated nurses and ADONs were responsible to update the care plan for Resident #23. ADON C stated care plan had to be updated as soon as possible when the order for the antibiotic was received. ADON C stated Resident #23 was at risk of not receiving the care that he needed. ADON said that they monitor any new orders during the morning meetings. During an interview on 05/13/25 at 4:27 p.m. the DON stated the care plan had to be updated to give the resident the best care and to verify if the interventions were effective. The DON stated the care plan had to be updated as soon as possible to give the best care to Resident #23. The DON stated Resident #23 was at risk of not receiving the proper care that he required. Record review of facility's Comprehensive Care Plans policy dated 10/24/22 reflected: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on interview and record review the facility failed to ensure Seroquel had a proper diagnosis for 1 (Resident #50) of 1 residents reviewed for drug regimen review, in that: The facility failed to address Seroquel (antipsychotic) being given to a resident with diagnosis of dementia. This deficient practice could place residents at risk of receiving unnecessary medications and dosages. The findings were: Record review of Resident #50's face sheet dated 05/13/25 revealed an [AGE] year-old male initially admitted to the facility on [DATE] with the diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a diagnosis of dementia where the type and severity are unknown, and there are no significant psychological or behavioral symptoms like aggressiveness, agitation, or psychosis), Hallucinations (a perception that someone experiences as real, but that has no actual external stimulus). Record review of Resident #12's care plan dated 05/10/21 revealed Resident #50 had impaired cognitive function and impaired processes related to lewy body dementia(a progressive neurodegenerative disorder characterized by the buildup of abnormal protein clumps called lewy bodies in the brain), black box warning: elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine (Seroquel) is not approved for the treatment of patients with dementia-related psychosis. Record review of Resident #50's MDS dated [DATE] revealed he had a BIMS score of 12, indicating he had moderate cognitive impairment. Resident #50's MDS section N-Medications, he had received antipsychotics on a routine basis only. Record review of Resident #50's Order Summary Report, dated 05/13/25 revealed, Seroquel Tablet 100 MG (Quetiapine Fumarate) Give 4 tablet by mouth two times a day related to lewy body dementia with behavioral disturbance. Start date of 1/10/25. During an interview on 5/13/25 at 10:50 a.m. LVN B stated Seroquel was an antipsychotic medication given for anxiety or insomnia. LVN B stated if an antipsychotic medication was given to a resident with dementia, Resident #50 could be drowsy. LVN B stated dementia was not a diagnosis for an antipsychotic medication. During an interview on 5/13/25 at 1:30 p.m. LVN E stated that she knew that lewy body dementia was not an appropriate diagnosis for an antipsychotic and that she called the Veterans office to clarify and was told that lewy body dementia was an appropriate diagnosis for the Seroquel. LVN E stated that a negative outcome could be resident declining, increase fall risk, and the resident could worsen his medical condition. LVN E stated that resident did not have any side effect to this medication. (continued on next page)

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	05/14/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/25 at 12:10 p.m. ADON C stated Seroquel was an antipsychotic used for depression. ADON C stated lewy body dementia was not an appropriate diagnosis for Seroquel because it could cause the opposite effect on the patient, increase lethargy, or an adverse reaction. ADON C stated that resident did not have any side effect to this medication. During an interview on 5/13/25 at 4:00 p.m. DON stated Physicians were the ones who orders antipsychotics and gave the diagnosis. The DON stated the negative outcome of giving a resident who has the diagnosis of dementia or Alzheimer's an antipsychotic for dementia or Alzheimer's could be adverse side effects. DON stated that resident did not have any side effect to this medication. DON said that the physician was called and stated that this diagnosis was for this medication. Record review of facility's policy on Use psychotropic Medication (s) dated 3/5/25 (implemented date 3/5/25), revealed: Policy Statement: it is the intent f this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.

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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. 50487 Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 (200 hallway cart) of 4 medication carts. The facility failed to ensure expired supplies and medications were removed from the nurses' medication cart for 200 hall. The facility's failures could place residents receiving medication at risk for drug diversion, lack of drug efficacy, and adverse reactions. Findings included: During an observation on 05/13/2025 at 02:48 PM of the 200 hall nurse's medication cart with LVN A revealed 1 box of famotidine 10milligrams with an expiration date of 4/2025. During an interview on 5/13/25 at 8:00 a.m. LVN A stated all of the nurses were responsible for checking for expiration dates on the medications and supplies in the medication carts. LVN A stated using the expired medications and supplies could lead to the medications and topical treatments not being as effective. During an interview on 5/13/25 at 12:10 p.m. ADON C stated taking the medication past the expirations date could lead to decreased effectiveness or ad verse effects including sickness. ADON C stated that nurses were responsible for checking the medication cart. During an interview on 5/13/25 at 4:45 p.m. the DON stated nurses, were responsible for ensuring expired medications were pulled from the medication carts. The DON stated that the negative outcome could be the medication was not as potent and resident would not receive the full benefit of the medication. The DON said that inservices were done quarterly on expired medications. DON said that she did routine rounds and checking the medication carts. Record review of facility policy Medication Administration dated 10/24/22 revealed Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Identify expiration date. If expired, notify nurse manager.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, interviews, and record reviews, the facility failed to maintain effective pest control for 1 of 1 facility in that: The facility failed to have pest control effectively treat the facility for roaches. This deficient practice could place residents at risk of exposure to pests, diseases, infections, and diminished quality of life. The findings include: During an observation on 05/13/2025 at 4:38 p.m., revealed a live roach on the floor in the hallway of the 400 hall. This observation was pointed out to LVN I, who immediately stepped on it, and walked away. Housekeeping staff swept the roach up. CNA J was charting in the hallway where the live roach came out. During an interview on 05/13/2025 at 4:40 p.m., CNA J stated that she has not seen roaches in the facility until now. She has not seen pest control, but she has heard that they do come in. During an interview on 05/13/2025 at 4:45 p.m., LVN I stated that she has not seen roaches in the facility that often. She stated that they have a pest control sighting logbook in place at the nurse's station where they were to document if they see any ants or roaches. Maintenance staff will take care of contacting pest control. Housekeeping staff takes care of cleaning up the pests. LVN I stated she has seen pest control come in. She stated the roaches can create all kinds of infections to the residents and the roaches can get on the resident's food. During an interview on 05/13/2025 at 4:50 p.m., Maint Dir stated that he was already informed of the live roach. He stated that pest control comes every month. They have a pest control sighting logbook at the nurse's station for the staff to document whenever they have a sighting of any bugs. He stated that housekeeping will go out and deep clean the room of where the bug was seen. Pest control would then be provided with a list of all sightings, and they spray accordingly. He stated the 400-hall nurse notified him and the housekeeping supervisor. The Maint Dir stated the negative outcome was that the roaches can get on the resident's food, belongings or on them. During an interview on 05/13/2025 at 4:57 p.m., Env Supv stated that sometimes they do have roaches but was rare. The staff notifies her if they see roaches or any other bugs. She will go see the room and put it on the pest control sighting logbook at the nurse's station. Maintenance will take care of it with the pesticide company. Her staff will go and deep clean the room. She stated pest control come out once a month. The Env Supv stated having a roach free facility was best for patient safety and to have a clean environment. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/13/2025 at 5:12 p.m., ADM, stated they have a pest control vendor entering the facility monthly and as needed. She stated that the roaches go with the weather when wet and they had recent flooding. The staff do rounds every morning to check the environment and would report any concerns they found. If there were any concerns, we do a deep clean in that room. She stated staff documents it in the pest control sighting logbook. They then discuss it in the morning meetings, and it gets entered into TELS. TELS sends maintenance a work order. ADM stated roaches in the facility were nasty, they could get in the resident's wounds and in their beds. She stated that they do not have a pest control policy. Record review of Pest Control sighting logbook revealed two entries for the month of April 2025- dated 04/01/2025 noted roaches in front of the restroom [ROOM NUMBER] and 04/21/2025 note live small roach at end of 200 hall. There was one entry for the month of May 2025, dated 05/12/2025 noted small roaches in bathroom. Record review of Pest Control Invoice, dated 04/25/2025, revealed the following services, Regular Pest Service and Flying Insect Program. Under General Comments/Instructions: Talked to contact, look over sighting log and inspected and treated rooms [ROOM NUMBER] for Roaches. Interior . Inspected and treated kitchen, dining, laundry, offices, employees area, hallways, bathrooms, and nurses station checked and changed glue boards as well. Exterior .Inspected and treated perimeter of building and replaced baits in rodent bait stations.