STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676066	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Concierge	2310 South Eldridge Parkway Houston, TX 77077

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on record review and interview, the facility failed to assess each resident annual assessment using the Annual Minimum Data Set (MDS) form specified by the state and approved by Center for Medicare and Medicaid Services (CMS) for review of 12-closed record and 1 of 5 Residents (Resident #1) reviewed for annual assessments. The facility failed to complete Resident #1's MDS Assessment within 124 days (11/08/2024 through 03/20/2025) of the previous MDS assessment. This failure could place all residents at-risk of not having their assessments completed timely. The findings included: Record review of Resident #1's Facesheet dated 03/20/2025 revealed Resident #1 was an 88-years old female who admitted to the facility on [DATE]. Resident's diagnosis included, but were not limited to unspecified dementia (group of symptoms effecting memory, thinking and social abilities), unspecified severity, without behavioral disturbance, psychotic disturbance (disassociation with reality), mood disturbance, and anxiety, bipolar disorder (mental illness/mood disorder causing periods of depression and periods of abnormal elevated mood), schizophrenia (mental illness/mood disorder causing hallucinations, delusions, and disorganized thinking) unspecified, encephalopathy (disorder disease of the brain causing disorientation, memory loss, and in severe cases, dementia or seizures), peripheral vascular disease (progressive disorder that causes narrowing or blocking of the blood vessels outside the heart leading to symptoms such as pain, numbness, weakness, skin discoloration, and slow wound healing), and hypertension (elevated blood pressure due to the consistent force of blood pushing against the artery walls). Record review of Resident #1's Quarterly MDS Quarter (Q2) dated 02/08/2025 with and Annual Review Date (ARD) of 02/08/2025 had an In Progress status. Completion due by 02/22/2025 - 26 days overdue. (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/2025 at 4:24 p.m., MDS Coordinator stated that she was responsible for ensuring that Resident #1's MDS assessment was uploaded timely. She stated that she had no excuse, but that the MDS had been completed on 03/20/2025 and could not be uploaded until completed. She stated that the facility had been working on timely uploads and had made it a QAPI/MDS topic. She stated process to upload time, was a work in progress. She stated the importance of an updating and uploading care plans was to ensure compliance, ensure timely payments, avoid state citations, and ensure patient received adequate care. During an interview on 03/20/2025 at 4:57 p.m., the Administrator stated that MDS assessments were to be completed annually and quarterly. He stated it had been his expectation that MDS assessments were completed and submitted within the required time frames, but that he was aware that some had not been uploaded timely. He stated he that MDS assessment were ongoing. He stated that he hired a clinical oversight nurse to help build a new Care Plan/MDS completion and uploading process. He stated that had recently hired a new Care Plan/MDS assistant. He stated that importance of timely submission was to ensure resident's most recent care goals and interventions were reflected. During an interview on 03/20/2025 at 05:09 p.m. DON stated that it was important to have an updated MDS uploaded timely to ensure that staff were aware of residents' current risks. She stated failure would affect the reflection on the resident's care plan. She stated if the care plan had not reflected current goals, the care plans could not reflect current interventions. She stated the staff relied on interventions to initiate care for the residents and without, the staff would not know what care each resident required. Record review of Policy titled Resident Assessment revised dated October 2023 revealed, Policy Statement Comprehensive assessment of each resident is completed at intervals designed by Omnibus Budget Reconciliation Act (OBRA) regulations and PPS requirements. Data from the Minimum Data Set (MDS) is submitted to the Internet Quality Improvement Evaluation System (iQIES) as required. Policy Interpretation and Implementation. 1. OBRA-Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessments include: a. Admission Assessment; b. Quarterly Assessment; c. Annual Assessment . 3. Comprehensive MDS assessments include both the completion of the MDS as well as completion of the Care Area Assessment (CAA) process and care planning. Comprehensive MDSs in [NAME] Admission, Annual, Significant Change in Status Assessment (SCSA), and Significant Correction of a Prior Assessment (SCPA). 4. Non-Comprehensive MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments a d to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. They do not include completion of the CAA process and care planning. Non-comprehensive assessments include Quarterly assessments and Situation, Complication, Question and Answer (SCQAs).

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on interview and record review the facility failed to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months for review of 1 of 5 Residents (Resident #1) and 12-closed records reviewed for assessments. The facility failed to complete a quarterly assessment for Resident #1 every 3 months (11/08/2024 through 03/20/2025). This failure could place residents at risk for not getting an accurate assessment and could result in lack of care. Findings include: Record review of Resident #1's Facesheet dated 03/20/2025 revealed Resident #1 was an 88-years old female who admitted to the facility on [DATE]. Review of Resident #1's last completed MDS assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 03 which indicated sever impaired cognition. Further review of Resident #1's MDS tracking record revealed the previous completed MDS was completed on 08/08/2024. The next MDS listed was a quarterly dated 02/08/2025 to be completed by 02/22/2025 that had an in progress status as of 03/20/2025 at 2:36 p.m. and showed 26-days overdue. During an interview on 03/20/2025 at 4:24 p.m., MDS Coordinator stated that she had not completed Resident #1's MDS assessment due by 02/22/2024 until 03/20/2025. Record review of policy titled MDS' - Completion and Submission Timeframes dated Revised October 2023 reflected: Our facility will conduct and submit resident assessments in accordance with current federal - and state submission timeframes. Policy Interpretation and Implementation. 1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' internet Quality Improvement Evaluation (iQIES). In accordance with current federal and state guidelines. 2. Timeframes for completioi1 and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.3. Submission of MDS records to the iQIES is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of fifteen (15) months from the date submitted.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on interview and record review, the facility failed to transmit ensure an MDS was completed and electronically transmitted to the CMS System for 14 days after completion resident assessment within the required time frame for 1 of 5 (Resident #1) and 12 closed records, reviewed for data transmission in that: The facility failed to complete and transmit Resident #1's quarterly MDS. This failure could place residents at risk of not having their assessments transmitted timely and an incomplete record. Findings Include: Record review of Resident #1's Facesheet dated 03/20/2025 revealed Resident #1 was an 88-years old female who admitted to the facility on [DATE]. Record review on 03/20/2025 at 02:35 p.m., revealed that Resident #1's quarterly assessment due 02/22/2025 showed an In Progress status and had not been uploaded. During an interview on 03/20/2025 at 4:24 p.m., MDS Coordinator stated Resident #1's MDS assessment was due by 02/22/2024. She stated it was transmitted late, 03/20/2025 and it had been her responsibility to upload timely. Record review of policy titled Care-Plans, Comprehensive Person-Centered revised dated March 2022. Policy Statement. A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical; psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative develops and-implements, a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission .

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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** 35822 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #42) of 11 residents reviewed for comprehensive care plans. - Resident # 42 was not care planned on 03/10/2025 for a PICC line insertion ordered on 03/07/25. These failure place resident at risk for infections and unwanted hospitalization . Findings included: Record review of Resident #42's face sheet dated 03/19/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident diagnoses included the following: sepsis (serious condition in which the body responds improperly to an infection), hypertension (elevated blood pressure), neuropathy (nerve damage), metabolic encephalopathy (when the brain is not functioning properly cause by a wide range of factors), pneumonia (infection in one or both lungs), and depression. Record review of Resident #42's Admission MDS dated [DATE] revealed a BIMS score of 11 indicating that resident cognition was intact. Further review section O (Special Treatments, Procedures, and Programs) reflected that resident was receiving IV antibiotic medications. Record review of Resident #42's Care Plan dated 03/10/25 did not reflect that resident was being car planned for having a PICC line. Record review of Resident #42's Physician Order Summary Report for the month of March 2025 reflected the following orders: -Dated 03/07/25 Cefazoline (antibiotic) intravenous (administration of fluid or medications in the vein) 2 grams three times a day for infected left knee wound until 04/10/25. Record review of Resident #42's MAR for the month of March 2025 reflected that the facility was administering resident antibiotic Cefazoline as ordered by the physician. Interview and observation on 03/18/25 at 9:32AM of Resident #42 resting in bed a wake. Resident had a PICC line to her upper right arm. Resident said she was receiving IV antibiotic therapy through her PICC line. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/20/25 at 4:25 PM with the MDS Coordinator said she was aware that Resident #42 had a PICC line and after she reviewed resident care plan the MDS Coordinator said she thought an IV peripheral (a short catheter placed in a superficial vein) was the same as PICC line (a longer catheter threaded into a larger vein near the heart) , the MDS Coordinator said resident was not care planned for a PICC line insertion. The MDS Coordinator said it was important that each resident had an individual comprehensive care plan to ensure that the nurses would know how to care for the resident. The MDS Coordinator said she would revise resident care plan to include PICC line insertion. Interview on 3/20/25 at 5:06PM with the DON said she was responsible in making sure that all the residents had individualized comprehensive care plans. The DON said when a resident was not care planned properly, the correct interventions cannot be followed to address goals. The DON said the facility had a total of 7 residents with central lines. The DON said although Resident #42 was care planned for an IV, a PICC Line insertion was not the same as a regular peripheral IV. The DON said if a PICC line was dislodge and resident continue to receive medications through the line, it placed the resident at risk for infiltration (fluids infusing in the surrounding tissue and not in the vein as intended) and possibly an embolism (foreign substance such as blood clot that travels through the blood stream and blocks a blood vessel). Record review of the facility policy on Care Plans, Comprehensive Person-Centered revised March of 2022 reflected in part: .A Comprehensive, person-centered care plan includes measurable objectives and timetable to meet the resident physical, psychosocial and functional needs is developed and implemented for each resident .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview and record review, the facility failed to ensure services provided by the facility, as outlined by the comprehensive care plan, met professional standards of quality for one (Resident #392) of one resident observed for gastrostomy tube feedings. The facility failed to ensure LVN B administered medication and water to Resident #392 via her gastrostomy tube (g-tube) by following physician's order These failures could place residents at risk for fluid overload weight loss, aspiration pneumonia, and abdominal discomfort. Findings included: Review of Resident #392's Admission Assessment reflected she was a [AGE] year old female who was admitted to the facility on [DATE]. Her diagnoses included gastrostomy tube (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach), dysphagia (difficulty swallowing), pneumonitis (swelling and irritation, also called inflammation, of lung tissue) due to inhalation of food and vomit, hyponatremia (lower than normal sodium/salt in blood stream), chronic thromboembolic pulmonary hypertension (cause by chronic pulmonary embolism (blood clots that form scar-like tissue in the lung's arteries, leading to blockage or narrowing of these arteries) and seizure disorder (is a condition where someone experiences recurring seizures, which are sudden bursts of abnormal electrical activity in brain that can cause temporary changes in behavior). Record review of Resident # 392's admission MDS dated [DATE] indicate a BIMS score 09 reflected moderate cognitive impairment. The MDS indicated that Resident # 392's was totally dependent on two or more staff for bed mobility, transfers, locomotion, dressing, eating, toilet use, and personal hygiene. Review of Resident #392's Baseline Care Plan, dated 02/28/25, reflected the following : Resident Dietary Orders as tube feeding, bolus. Goal: No signs of symptoms of aspiration Intervention: elevate head of bed at 35 degrees at all times Review of Resident #392's Physician's Orders dated 2/26/25 reflected the following orders: Had NPO (Nothing per oral) GT: Flush feeding tube with 30 ml water before and after administration of meds, flush with 10 cc between each medication every shift. Observation and interview on 03/19/25 at 8:10 a.m. revealed LVN B was in process of passing medications to Resident #392. During medication pass for Resident # 392, LVN B crushed the following medications. LVN B attached 60 cc of G-Tube syringe, she checked for placement and instilled 60 cc of water before administering medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sodium Chloride tab 1gm 2 tablets dissolve in 20cc water via G-Tube Atenolol 100 mg 1tablet diluted with 5cc of water via G-Tube Atorvastatin 10 mg 1 tablet diluted with 5cc of water via G-Tube Calcium 600mg + D5 mcg 1 tablet diluted with 5cc of water via G-Tube Eliquis 2.5 mg 1 tablet diluted with 5cc of water via G-Tube Fluoxetine 20mg 1 cap diluted with 5cc of water via G-Tube Furosemide 40 mg 1 tablet diluted with 5cc of water via G-Tube Lamotrigine 25 mg 1 tablet diluted with 5cc of water via G-Tube LVN B used 630cc of water total of flush via Resident #392's G-Tube. LVN B had (7 ounces x 3 cups: each cup had 210 cc of water =630cc). During medications administration on 3/19/25 at 8:10 a.m., Resident #392 complained to LVN B of being too full, while administering medication. In an interview with LVN B on 3/19/25 at 8:45 a.m., regarding the amount of water instilled via Resident #392's G-Tube during medication administration, LVN B said I was trying make sure that the medications were all gone via tubing . LVN B was asked by the surveyor, how much water was Resident #392 supposed to get with medication pass, LVN B checked Resident #392's MAR and added total water was 140 cc and said she did not calculate the amount of water she gave, it was 630 cc. LVN B said giving Resident #392's too much water could cause fluid overload and aspiration and confirmed hearing resident complaining of being too full. In an interview on 03/19/25 at 5:21 p.m. the DON said she expected her nurses to ask for help if they felt uncomfortable or needed help with a task. She said she expected nurses to give medications, water via G-Tube as ordered by the physician, and if they had a question about an order, they needed to call the physician for clarification. DON said LVN B did not have any orientation on G-Tube, the ADON hired LVN B. ADON should have given LVN B skills orientation on hired. In an interview with ADON on 3/19/25 at 5:56 p.m. she said another RN, who no longer works for the facility was the one that gave LVN B orientation. Record review of LVN B competency skills orientation had hired date on 1/14/2025 and there was no signature on the competency skills orientation performance objectives. Review of the facility's Administering Medications through an Enteral Tube policy, dated November 2018, reflected: Procedure (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Preparation: 1. Verify that there is a physician's medication order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed. 9. Dilute Medication: a. Remove plunger from syringe. Add medication and appropriate amount of dilute. B. Dilute crushed (powdered) medication with at least 30 ml purified water (or prescribed amount) c. Dilute liquid medication with 30 ml or more (depending on viscosity) purified water. Remove plunger from syringe and insert into tubing. .Allow medication to flow down tube via gravity . Managing Complications. If the feeding tube becomes clogged, intervention should occur immediately. Warm water should be tried first. Do Not force-flush tube or use a rigid object in an attempt to clear the tube. If clog is persistent, contact the Medical Doctor (MD) if the above techniques fail . Review of the Texas Administrative Code Title 22, Part 11, Chapter 217, Standards of Nursing Practice (TACS217.11(1)(T)]), retrieved from http://www.bon.texas.gov/rr_current/217-11. asp on 03/18/19, reflected the following: (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall: . (G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices. (H) Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations; .

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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** 36918 Based on observation, interview, and record review the facility failed to provide the necessary services to maintain grooming and personal care for 2 (Resident #195 and Resident #192) of 7 residents reviewed for ADL care, in that: - The Ffacility failed to give Resident #195 his schedule showers on Tuesday, Thursday, and Saturday on a consistent basis. - The facility failed to ensure Resident #192 was provided incontinent care in a timely manner. These failures placed residents a risk for skin break down, offensive odors, and decrease in quality of life. Findings: Resident #195 Record review of Resident #195's face sheet dated 03/20/25 revealed a [AGE] year-old female was admitted to the facility on [DATE]. Resident #195 had diagnoses included: diabetes mellitus (Body do not produce enough insulin or cannot effectively use insulin), hypertension (blood pushing against the artery walls is consistently too high) and absence of right leg below knee (surgical removal of right). Record review of Resident #195's admission MDS assessment dated [DATE] revealed the BIMS was 12 which indicated moderately impaired cognition. Resident #195 needed moderate assist with ADLs with one staff assistance. Record review of Resident #195's undated care plan revealed Resident #195 requireds assistance with all ADLs. Interventions: provide ADL care daily. Record review of the facility showers sheets for Resident #195's unit with the DON for March 2025 revealed there were no shower sheets for Resident #195. The DON said no shower sheets it would mean Resident #195 did not get any shower. During an observation and interview on 03/18/25 at 10:03 a.m., Resident #195 said she was admitted to the facility on [DATE], and she asked about her shower, and the staff told her she would get a shower on Thursday. Resident #195 said she was told she could not get a shower because of the wound on her foot. Resident #195 said she asked about getting a bed bath, and the staff said she would give her a bed bath on Thursday, but the staff had not given any bed bath or shower up to today. Resident #195 said she could not remember the names of the staff she talked to about showers or bed baths. She showered her arms and legs and said see how dry and ashy my skin is. Resident #195 said the staff had not applied lotion on her, and when she asked the staff to apply lotion, the staff did not apply the cream. Resident #195 said her skin is itching, and she does not feel clean. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/19/25 at 9:22 a.m., Resident #195 said she asked the staff again for a shower or bed bath yesterday (3/18/25), and the staff did not give her a shower again. During an interview on 03/20/25 at 2:08 p.m., the DON said the facility had scheduled showers three times a week and as needed for all residents. The DON said she was unaware that Resident #195 was refusing to shower, and that the unit manager was in charge of Resident #195's unit. The DON said Resident #195 would have skin breakdown, dry skin, and smell bad, and she stated the resident would feel so bad. The DON said the aides are responsible for giving Resident #195 a shower, and the aide would notify the change nurse if Resident #195 refused to shower. The charge nurse would go to the resident and encourage the resident to take a shower. The DON said if Resident #195 refused, the nurse would document on Resident #195's chart that the resident refused to shower. During an interview on 03/20 /25 at 2:41 p.m., CNA N said she did not shower Resident # 195 because she refused to shower. CNA N said she told her nurse but could not remember the nurse's name, so the nurse asked her to sign the shower sheet. CNA N said she gave the shower sheet to the nurse. CNA N said residents are showered every other day. She said if Resident #195 did not get a shower, the resident would not smell good, and the resident's skin would be dry and even break down. CNA N said Resident #195 would feel bad if she did not get a shower. She said she had in-service and skill check-offs on showering residents. She said the unit manager trained her on how to shower a resident last year, and if the resident refused to shower, then the aide would tell the nurse and document the refusal on the shower sheet. During an interview on 03/20/25 at 2:55 p.m., CNA K said she could not remember if she gave a shower to Resident #195. CNA K said the aide filled out the shower sheets when a resident was given a shower. She said the aides are responsible for showering residents, and if the resident refused, then she would write refuse on the shower sheets. CNA K said Resident #195's skin would be dry and itching, and the resident would not feel comfortable. CNA K said she had skills check-off and in-service on the shower. She said she was told to gather all the supplies, take them to the shower room, and take the resident to the shower room. If the resident refused, she would tell the nurse and document it on the shower sheet. CNA K said the nurse monitored the aides throughout the shift. During an interview on 03/20/25 at 3:33 p.m., RN S said none of her aides had told her Resident #195 refused to shower. RN S said Resident #195's skin would look dry and itching, and the resident would not feel good. She said the nurse monitors the aide throughout the shift. RN S said she would sign the shower sheet but did not remember signing any shower sheets for Resident #195. She said the nurse manager monitors the nurse during random rounding. She said she had in-service on skin integrity. During an interview on 03/20/25 at 4:49 p.m., the Unit Manager said the aides give showers to residents every other day unless the resident requested or refused. The Unit Manager said the aide could document on the shower sheet or put it on the POC if a resident was given a shower or not. The unit Manager said the aide should report to the nurse if any resident refused to shower, and the nurse would go and talk to the resident. If the resident refused, then the nurse would not have to document the resident refusal on the progress note because the nurse would sign the shower sheet that the resident refused. The Unit Manager said Resident #195 would feel dirty if she did not get a shower. She said she looked for Resident #195 shower sheet but could not find any shower sheets for Resident #195. She stated the resident skin would feel dry and unclean. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Concierge	2310 South Eldridge Parkway Houston, TX 77077

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #192 Record review of Resident #192's face sheet dated 03/20/25 revealed an [AGE] year-old female was admitted to the facility on [DATE]. Resident #192 had diagnoses included: diabetes mellitus (Body do not produce enough insulin or cannot effectively use insulin), hypertension (blood pushing against the artery walls is consistently too high) and atrial fibrillation (irregular and often rapid heartbeat). Record review of Resident #192's admission MDS assessment dated [DATE] revealed Resident BIMS was 12 which indicated moderately impaired cognition. Resident #192 needed extensive assistance with ADL with one to two staff assistants. Record review of Resident #192's care plan initiated on 03/19/25 revealed Resident #192 had bladder/bowel incontinence related to mobility. Interventions: check for incontinence as needed. During an observation and interview on 03/19/25 at 8:30 a.m., Resident #192 was lying in bed on her back, and she had a hospital gown on. The Resident's gown was wet, and Resident #192 said you finally came to change me. The surveyor asked Resident #192 what happened, and she said she was soaked with urine. She had been asking for help, and none of the staff had come to change her. Resident #192 said the last time the staff changed her was at midnight. Resident #192 said she had her call light on, and none of the staff had come to change her. Resident #192 said her bottom was burning, and she pointed her hand down to her perineal and abdominal fold. During an observation and interview on 03/19/25 at 8:44 a.m., Resident #192 pulled her call light again, and staff went into her room and turned off her call light. The housekeeping Manager said Resident #192 pulled her call light because she had been waiting for a while for the aide to come and change her because she was wet. She said she was going to get an aide to change the resident. During an observation on 03/19/25 at 9:00 a.m., incontinent care for Resident #192 revealed the resident hospital gown, disposal draw sheet, cloth draw sheet, and fitted bed linen were wet with urine. Resident #192 incontinent brief was saturated from front to back. The inside of the incontinent brief was dark yellow, and the wet indicator faded out. Resident #192 was soaked with urine from her lower back to the upper part of her upper thigh. Resident #192 had redness and excoriation under her abdominal fold, peri area and buttocks and in-between her buttocks. During an interview on 03/19/25 at 9:44 a.m., CNA O said Resident #192 was assigned to her, and she came to work at 6:00 a.m. CNA O said she went and checked Resident #192's blood pressure and she asked her if she was okay, and the resident said she was fine. CNA O said she checked the residents blood pressure between 6:15 a.m. and 6:30 a.m. CNA O said she observed Resident #192 disposable draw sheet, cloth draw sheet, resident gown, and fitted linen were saturated with urine while they were providing incontinent care. She stated the residents incontinent brief was also saturated, and the wet indicator line was no longer visible. CNA O said Resident #192 peri area could become red, causing skin breakdown and infection. CNA O said she had training on incontinent care, and aides make rounds every two hours and as needed. CNA O said the nurse monitored the aides throughout the shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 10:20 a.m., CNA J said she was not the aide for Resident #192 but was told to go and provide incontinent care. CNA J said Resident #192's gown, disposable pad, and draw sheet were wet from urine. She stated the resident incontinent brief was saturated, and the wet indicator line was very faded out. CNA J said the aides are supposed [NAME] make rounds every two hours and PRN make rounds every two hours. She said it was more than two hours because the urine inside the brief was dark yellow. CNA J said Resident #192 skin could break down, and she could have a UTI. During an interview on 03/20/25 at 11:58 a.m., the DON said the aides should make rounds at the start of the shift, at least every couple of hours, and as needed throughout the shift. The DON said Resident #192 could get skin breakdown or have an infection UTI if she was left in a wet, incontinent brief for an extended time. The DON said the floor nurses monitored the aides throughout the shift, and the unit manager monitored the nurses during random rounds. During an Iinterview on 03/20/25 at 4:25 p.m., the Unit Manager said the aides are responsible for making rounds for incontinent care and the aides should make rounds every two hours. The Unit Manager said if Resident #192 was left in a saturated incontinent brief for an extended period of time, the resident's skin could break down. The Unit Manager did not respond to what was considered extended time. She said the nurses monitored the aides during rounds, and she monitored the nurses during random rounds. Record review of the facility policy on Activities of Daily Living (ADL), Supporting revised March of 2018 reflected in part: .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 44669 Based on observation, interviews, and record review the facility failed to provide, based on the preferences of each resident, activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 5 of 5 confidential residents reviewed for activities. The facility failed to provide activities to meet the residents' interests on Saturdays and Sundays for 5 confidential residents. These failures placed residents at risk for decline in quality of life, social and mental psychosocial wellbeing. Findings Include: During a confidential group interview on 03/19/2025 and 10:04 a.m., with 5 confidential residents, all residents stated that there are no weekend activities. They stated that they could attend church on Sundays, but no other activities were provided. They stated that they would love to have weekend activities, as it was boring. They stated that the only time they had weekend activities was when the Activities Director was on shift during the weekend once a month. During an interview with the Activities Director on 03/19/2025 and 03:09 p.m., she stated that she worked Monday through Friday from 8:30 a.m. to 5:00 p.m., providing activities to the residents. She stated on weekends she was off, except once a month when she was the manager on duty she would offer Bingo on Saturdays. She stated on weekends, residents had free time to do whatever they wanted. She stated she would leave uno, coloring books and dominos out on each unit. She stated that she had also encouraged the resident council president who liked to lead dominos games to get out her room and encourage others to join and introduce herself to other new residents. She stated she would leave canvases and paint but would not want to leave residents unsupervised with the paint. She stated that the facility was in the process of hiring an assistant activities director, but she had been the only staff offering resident's activities for many years. She stated that census has increase quite a bit during the last 3 years as well. During an interview with the Administrator on 03/19/2025 at 03:33 p.m., he stated that that facility had not had a weekends activities director. He stated that he was difficult to staff a weekend activities director. He stated that the Activities Director came in 1x a month and offered activities, otherwise residents were offered self-guided activities. He stated he was looking to have an assistant activities director join next week. Record Review of the Activities Calendar for January 2025, the following Saturday dates 01/04/2025, 01/11/2025, 01/18/2025, and 01/25/2025 had Independent Activities (Available on Each Unit), Jig Saw puzzle on the Units, Puzzles, Checkers, Cards,10:00 matinee movies. On the following Sunday dates 01/05/2025, 01/12/2025, 01/19/2025, and 01/26/2025, 10:00 Sunday Matinee, 1:00 Church / Pastor, 4:00 Self-Guided activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the Activities Calendar for February 2025, the following Saturday dates 02/01/2025, 02/08/2025 and 03/15/2025 and 03/28/2025 had Independent Activities (Available on Each Unit), 10:00 matinee movies. On the following Sunday dates 02/02/2025, 03/16/2025, and 02/22/202510:00 Sunday Matinee, 1:00 Church / Pastor, 4:00 Self-Guided Reading. Record Review of the Activities Calendar for March 2025, the following Saturday dates 03/01/2025, 03/15/2025 and 03/29/2025 had Independent Activities (Available on Each Unit), Jig Saw puzzle, Deck of cards and 10:00 matinee movies. On 03/08/2025 Independent Activities (Available on Each Unit) Adult Coloring, Deck Of Cards, Dominos, and 10:00 matinee movies. On 03/22/2025 Independent Activities (Available on Each Unit), Jig Saw puzzle, 9:00 Bingo and 10:00 matinee movies. On the following Sunday dates 03/02/2025, 03/09/2025, 03/16/2025, 03/23/2025, 03/30/2025, Independent Activities (Available On Each Unit), 1:00 Church / Pastor, 4:00 Self-Guided activities. During a review of Facility's policy Activity Programs dated revised June 2018, revealed: Policy Statement. Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well a-being of each resident. Policy Interpretation and Implementation. 1. The activities program is provided to support the well-being of residents and to encourage both independence and community interaction . 4. Activities are considered any endeavor, other than routine AD Ls, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. 5. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. 6. Activities are scheduled 7 (seven) days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs. 7. Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interests of each resident. Activity programs include activities that promote: a. self-esteem; b. comfort, c. pleasure, d. education; e. creativity; f. success; and g. independence

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview and record review, the facility failed to ensure that parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 out of 7 residents (Resident # 42) reviewed who were receiving parenteral fluids. -The facility failed to change Resident # 42's PICC line (a longer catheter threaded into a larger vein near the heart) dressing every 7 days as ordered by the physician. -LVN B failed to measure Resident #42's external PICC line catheter prior to removing the old dressing to ensure that the tip of the catheter had not dislodged. -LVN B failed to properly remove Resident #42's PICC line dressing to prevent dislodgement. These failures placed resident at risk for infections, injuries, unwanted hospitalization , and decrease in quality of life. Findings: Record review of Resident #42's face sheet dated 03/19/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident diagnoses included the following: sepsis (serious condition in which the body responds improperly to an infection), hypertension (elevated blood pressure), neuropathy (nerve damage), metabolic encephalopathy (when the brain is not functioning properly cause by a wide range of factors), pneumonia (infection in one or both lungs), and depression. Record review of Resident #42's Admission MDS dated [DATE] revealed a BIMS score of 11 indicating that resident cognition was intact. Further review section O (Special Treatments, Procedures, and Programs) reflected that resident was receiving IV antibiotic medications. Record review of Resident #42's Care Plan dated 03/10/25 did not reflect that resident was being care planned for having a PICC line. Record review of Resident #42's Physician Order Summary Report for the month of March 2025 reflected the following orders: -Dated 03/07/25 Cefazoline (antibiotic) intravenous (administration of fluid or medications in the vein) 2 grams three times a day for infected left knee wound until 04/10/25. -Dated 03/15/25 Change IV dressing every 7 days and PRN every evening shift on Sunday. -Dated 03/20/25 Stat chest X-ray to verify PICC line placement. Record review of Resident #42's MAR reflected that the facility was administering resident antibiotic Cefazoline as ordered by the physician. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/18/25 at 9:32AM of Resident #42 resting in bed awake. Resident had a PICC line to her upper right arm. The dates on the dressings read: Date of insertion 02/28/25, changed 03/07/25, and next date to be changed 03/14/25. Resident said she was receiving IV antibiotic therapy . Observation on 03/20/25 at 9:35AM, Resident #42 awake in bed watching TV. Observation of resident PICC line to the right arm with dressing that reflected the following: -Date of insertion 02/28/25 -Dressing change date: 03/07/25 -Next date to change: 03/14/25 Record Review on 03/20/25 of Resident #42's TAR for the month of March 2025 reflected that resident PICC had been changed on 03/16/25 by LVN D. Interview on 03/20/25 at 9:50AM, LVN B said she was the nurse for Resident #42. After LVN B observed the PICC line dressing, LVN B said the last time resident dressing had been changed was on 03/07/25 and the dressing needed to be changed. LVN B said she worked at the facility PRN. LVN B said she worked at the facility on 03/19/25 and was Resident #42's nurse on that day. LVN B said the reason she did not change the PICC line dressing on 03/19/25 was because she got busy and lost track of time. LVN B said she would change Resident #42's PICC line dressing. LVN B said PICC line dressings were supposed to be changed weekly. LVN B said if the dressing was not changed weekly, it placed the resident at risk for infections and skin breakdown. LVN B said although she worked at the facility on a PRN basis, she had been in-serviced on central line dressing changes . Interview on 03/20/25 at 10:44AM, the DON said PICC line dressing changes was supposed to be changed every 7 days to decrease infections. The DON said it was the Unit Manager who was supposed to make sure that the nurses were doing this along with the ADON as well as herself. The DON said each of them were assigned to a unit to make sure that the unit nurses were completing this task along with other assignments . Interview on 03/20/25 at 10:50AM, the ADON said she was assigned to the unit that Resident #42 resided on. The ADON said she ensured that the nurses were completing their assignments by making rounds typically on a Monday. The ADON said she was out sick on Monday 03/17/25. The ADON said she was not trying to make excuses because there was an order in place to change resident PICC line dressing every 7 days. The ADON said if Resident #42's dressing to her PICC line was not being changed as ordered, it placed resident at risk for an infection. The ADON said she was also the facility Infection Control Preventionist. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/20/25 via phone at 12:30PM, RN E said she worked at the facility PRN. RN E said she was familiar with Resident #42. RN E said she worked at the facility on 03/15/25 on a Saturday. RN E said she was aware that resident had a PICC line. RN E said she looked everywhere in the facility for a central line dressing kit but could not find one. RN E said she did not recall reaching out to the DON or anyone else regarding where the central dressing kits were stored. RN E said the protocol was to reach out to upper management if she could not locate a specific item regarding the care of a resident. RN E did not reply when ask why she did not. RN E said if Resident #42's PICC line dressing was not changed as order, it placed the resident at risk for infection. RN E said she gave report to the oncoming nurse who name she did not recall and told her that the PICC line dressing for Resident #42 needed to be changed on 3/16/25 due to her not being able to find a central line dressing change kit. RN E said the nurse did not respond but kept writing and taking report. Observation on 03/20/25 at 2:25PM of PICC line dressing change for Resident #42 by LVN B. LVN B entered the room with 2 central line dressing change kits, sanitized her workspace, and washed her hands. LVN B said the reason she took 2 central dressing kits in Resident #42's room was because this technique made her feel more comfortable. LVN B began to open one of the kits and removed a sterile pair of gloves to remove resident old PICC line dressing. Prior to removing the old dressing, LVN B did not measure the length of the external tubing starting at the site to compare at the end of dressing change to ensure the catheter tubing remained in the same place. While removing the old dressing, LVN B began to remove the adhesive dressing by pulling away from the PICC line site instead toward the site to prevent dislodging the PICC line. LVN B proceeded to remove the Statlock (an adhesive device that sticks to the arm to secure placement and prevent excessive movement). The PICC line site was free of any redness, drainage, or swelling. LVN B walked away from the bedside to sanitize her hands and returned to open the second kit placing on a new set of sterile gloves to clean the PICC line site. When LVN B finished cleaning the site, she placed a transparent (thin see-through film dressing) dressing over the site and then tried to measure the external catheter tubing. Interview on 03/20/25 at 2:52PM with LVN B said she thought she did okay but was nervous when changing Resident #42's PICC line dressing. LVN B said she forgot to measure the external length of resident PICC line prior to removing the old dressing. LVN B said if the PICC line was dislodged, it placed the resident at risk for medications not being infused properly. LVN B said it also placed the resident at risk of for an infection or a blood clot. Interview on 03/20/25 at 3:05PM with the ADON said central line kits were kept on the units as well as in the Central Supply Room. The ADON said if a nurse is having difficulty locating supplies and it was on a weekend, the protocol is to contact whoever was on call for the weekend. The ADON said the administrative staff took turns for call that consisted of herself, the DON, and the Unit Manger but if the nurse was unable to contact person designated for on call, the other administrative staff members were easily accessible via phone. Observation on 03/20/25 at 3:08PM of the facility Central Supply Room having 5 central line dressing kits. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/20/25 at 4:25PM with the DON said the facility had a total of 7 residents with central lines. The DON said LVN B had received in-service on Central Line dressing changes and would provide the survey a copy of LVN B's training. The DON said it was the pharmacy that ordered central line kits for the facility on residents that had a central line/PICC line. The DON said although the central supply room had 5 central line dressing kits with other central line dressing kits on the units, she was going to request a PAR level of 10 (the minimum quantity of an item that should be on hand to meet resident demand) central line kits be always accessible in the central supply room. Further interview with the DON said when the nurse is removing the old central line dressing, the dressing should be removed by taking the dressing off moving toward the PICC line site to avoid dislodging the PICC line. The DON said prior to the nurse removing the dressing, the external tubing of the PICC line should be measured to ensure the line had not moved after the dressing change was done. The DON said a measurement should be taken prior to removing the old dressing to ensure the catheter had not moved. The DON said the purpose of the StatLock is to prevent the PICC line from dislodging and that the nurse should not have removed the StatLock. The DON said if a PICC line is dislodge and resident continue to receive medications through the line, it placed the resident at risk for infiltration (fluids infusing in the surrounding tissue and not in the vein as intended) and possibly an embolism (foreign substance such as blood clot that travels through the blood stream and blocks a blood vessel). The DON said she would call the physician for an x-ray of the PICC line to ensure the catheter tip of the PICC line was still in the right place internally before administering anything else through the PICC line. The DON said she was going to in-service LVN B along with the other nurses on central line/PICC line dressing changes. The DON was asked for LVN B's training on PICC line dressing changes. The DON did not provide LVN B's training on PICC line dressing changes. Interview on 03/20/25 at 4:36PM with LVN D said she worked the 2PM-10PM shift full time. LVN D said she made a mistake when she documented on resident TAR for the month of March 2025 on the 16th that she had changed resident PICC line dressing when she did not. LVN D said she became busy on that day and forgot to complete the task of changing resident PICC line dressing. LVN D said she was not supposed to document that she completed a task until after the task was done. LVN D did not say why she done this. Record review of in-service dated 03/20/25 reflected that the DON had in-service the Nursing staff including LVN B on PICC line dressing changes . Record review of the facility policy on Central Venous Catheter Care Dressing Changes revised March of 2022 reflected in part: .The purpose of this procedure is to prevent complications associated with intravenous therapy including catheter related infections that are associated with contaminated, loosened, soiled, or wet dressings . maintain sterile dressings for all central vascular access devices .change dressing at least every 7 days . measure the length of the external central vascular access device with each dressing change .remove the dressing in the direction of the catheter insertion (from the hub of the catheter toward the head) to avoid dislodging the catheter .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview and record review, the facility failed to ensure that its medication error rate was not 5 percent or greater. The medication error rate was 14 percent with 5 errors out of 35 opportunities involving 1 of 3 staff members (LVN B) and 2 of 7 residents (Resident #392, Resident #393) reviewed for medication administration. - LVN B administered 3 medications to Resident #392 via PEG tube (feeding tube) in a manner that was not in accordance with accepted professional standards and principles. She crushed the medications into a powder form in each medication cup, dissolved it in water, LVN B did not ensure she got all the medication out of the medication cup during administration. - LVN B failed to administer doxycycline monohydrate and did not follow order when she also administered antacids, vitamins or iron without waiting for 2 hours as ordered for Resident #393. This failure could place residents at risk of their medications not being administered in accordance with professional standards of practice or physician's orders, which could place residents at an increased risk of experiencing adverse effects such as drug to drug interactions or alterations in therapeutic drug levels. Findings Include: Review of Resident #392's Admission Assessment reflected she was an [AGE] year old female who was admitted to the facility on [DATE]. Her diagnoses included gastrostomy tube (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach), dysphagia (difficulty swallowing), pneumonitis (swelling and irritation, also called inflammation, of lung tissue) due to inhalation of food and vomit, hyponatremia (lower than normal sodium/salt in blood stream), chronic thromboembolic pulmonary hypertension (cause by chronic pulmonary embolism (blood clots that form scar-like tissue in the lung's arteries, leading to blockage or narrowing of these arteries) and seizure disorder (is a condition where someone experiences recurring seizures, which are sudden bursts of abnormal electrical activity in brain that can cause temporary changes in behavior). Record review of Resident # 392's admission MDS dated [DATE] indicated a BIMS score 09 reflected moderate cognitive impairment. The MDS indicated that Resident # 392's was totally dependent on two or more staff for bed mobility, transfers, locomotion, dressing, eating, toilet use, and personal hygiene. Review of Resident #392's Physician's Orders dated 02/26/25reflected the following orders: Had NPO (Nothing per oral) only GT: Flush feeding tube with 30 ml water before and after administration of meds, flush with 10 cc between each medication every shift. Record review of Resident #392's physician's summary order's and MAR had start date of 3/14/25 for the followings medications: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676066	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Concierge	2310 South Eldridge Parkway Houston, TX 77077

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. FLUoxetine HCl Oral Tablet 20 MG (use to treat depression, and sometimes obsessive compulsive disorder and bulimia) Give 1 tablet via G-Tube one time a day for Depression. 2. Lamotrigine Oral Tablet 25 MG ((used to treat partial seizures, primary generalized tonic- clonic, bipolar 1 disorder maintenance and lennox-Gastaut syndrome) Give 1 tablet via G-Tube two times a day for Seizure. 3. Atorvastatin Calcium Oral Tablet 10 MG ((a class of medicines used to lower cholesterol) Give 1 tablet via G-Tube one time a day for Hyperlipidemia. Observation and interview on 03/19/25 at 8:10 a.m., revealed LVN B was passing medications to Resident #392. During medication pass for Resident # 392, LVN B crushed the following medication. Atorvastatin 10 mg 1 tablet diluted with 5cc of water via G-Tube and was floating in the water. Fluoxetine 20mg 1 cap diluted with 5cc of water via G-Tube Lamotrigine 25 mg 1 tablet diluted with 5cc of water via G-Tube LVN B attached 60 cc of G-Tube syringe, she checked for placement and instilled 60 cc of water before administering medications. LVN had did not administered all the medication via the syringe, she had medication left in the 3 medicine cups and discarded medication cups, LVN B kept pouring water via the syringe. In an interview with LVN B on 3/19/25 at 8:45 a.m LVN B said I was trying make sure that the medications were all gone via tubing . LVN B said she forgot to rinse those medication cups and knew Resident #392's not getting all her medication during medication pass, could affect therapeutic drug level in her blood. Resident #393 Record review of Resident #393 was admitted date was 3/11/25 and the diagnosis included: sepsis, unspecified organism, acquired absence of left leg below knee, acquired absence of right leg below knee, type 2 diabetes mellitus with hyperglycemia (a condition where the body either doesn't produce enough insulin or doesn't use insulin properly, leading to high blood sugar levels), morbid (severe) obesity due to excess calories (is a severe form of obesity characterized by a body mass index (BMI) of 40 or higher which is related to health complications), major depressive disorder, recurrent (is a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy) gastro-esophageal reflux disease with esophagitis (gastric reflux), hyperlipidemia (a medical condition characterized by abnormally high levels of fats(lipids) in the blood). Record review of Resident # 393's admission MDS dated [DATE] indicate BIMS score 12 reflected moderate cognitive impairment. The MDS indicated that Resident #393's was totally dependent on two or more staff for bed mobility, transfers, locomotion, and personal hygiene. Record review of Resident #393's physician's summary order's and MAR had start date of 3/12/25 for the followings medications: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Multivitamin Oral Tablet (Multiple Vitamin) Give 1 tablet by mouth one time a day for Supplement. - Vitamin C 500 mg tablet po Give 1 tablet by mouth one time a day for Supplement -Doxycycline Monohydrate 100 MG Capsule, Give 1 capsule by mouth two times a day for Stomp wound for 10 Days TAKE WITH FULL GLASS, OF WATER TAKE WITH FOOD /IF STOMACH UPSET MAY CAUSE INCREASE PHOTOSENSITIVITY, NO ANACIDS, VITS OR IRONWITHIN 2 HOURS Observation on 3/19/25 at 9:00 a.m., during medication administration to Resident #393, LVN B punched Vitamin C 500 mg 1 tablet, Multivitamin 1 tablet, Doxycycline Monohydrate 100 MG Capsule and other medications and administered to Resident #393's by mouth. LVN B did not wait for 2 hours before administering Multivitamin Oral Tablet and Vitamin C 500 mg tablet po. Observation on 3/19/25 at 9:00 a.m.,of Doxycycline Monohydrate 100 MG Capsule by mouth blister packet had highlighted Take with /Full glass of water take W/Food if stomach upset occurs May Cause increased Photosensitivity. No antacid, vitamins, irons, dairy within 2 hours. - In an interview with LVN B on 3/19/25 at 2:00 PM after showing her the blister packet of Doxycycline Monohydrate 100 MG Capsule regarding administering Doxycycline with vitamin C, multivitamin, she said she did not look at the label on the blister packet and she had in-services on medication pass on insulin and she had been a nurse for many years, she knew giving Doxycycline with vitamin C, multivitamin, could cause stomach upset. In an interview with the DON on 3/19/25 at 5:21 p.m., regarding medications blister packet pharmaceutical recommendation on medications blister packet not being followed, she said the staff are expected to follow pharmaceutical recommendation to avert drug interaction and the G-tube medication should be given in totality as ordered by the doctor. The DON said not administering medication as ordered could affect therapeutic level in resident blood. The DON said LVN B did not have any orientation on G-Tube, the ADON hired LVN B. ADON should have given LVN B skills orientation on hired. In an interview with the ADON on 3/19/25 at 5:56 p.m. she said another RN, who no longer works for the facility was the one that gave LVN B orientation. Record review of LVN B competency skills orientation had hired date ofn 1/14/2025 and there was no signature on the competency skills orientation performance objectives. Record Review of facility's policy Medication Administration Procedures with revised date of April 2019 revealed . 4. Medications are administered in accordance with prescriber orders, including any required time frame. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5.Medication administration times are determined by resident need and benefit, not staff convenience. Factor that are considered include: a. enhancing optimal therapeutic effect of the medication, b. preventing potential medication or food interactions. 10. The individual administering the medication checks the label THREE(3) times to verify right resident, of medication should always be adhered to which includes the right medication, right dosage, right time and right method (route) of administration before giving the medication and the right dose.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observations, interviews, and record reviews, the facility failed to ensure that residents were free of significant medication errors for 1 (Resident #392) of 7 residents reviewed for pharmacy services. The facility failed to ensure Resident #392 was free of significant medication errors when Resident #392, atorvastatin (medication to treat high cholesterol), Lamotrigine (medication to treat seizure), and Fluoxetine (which is an antidepressant) was administered by LVN B on 03/19/2025. LVN B failed to administer 3 medications to Resident #392 via PEG tube (feeding tube) in a manner that was not in accordance with accepted professional standards and principles. She crushed the medications into a powder form in each medication cup, dissolved it in water, LVN B did not ensure she got all the medication out of the medication cup during administration. This failure could place residents at risk of adverse reaction related to taking medications not ordered by the physician. Findings included: Review of Resident #392's Admission Assessment reflected she was a [AGE] year old female who was admitted to the facility on [DATE]. Her diagnoses included gastrostomy tube (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach), dysphagia (difficulty swallowing), pneumonitis (swelling and irritation, also called inflammation, of lung tissue) due to inhalation of food and vomit, hyponatremia (lower than normal sodium/salt in blood stream), chronic thromboembolic pulmonary hypertension (cause by chronic pulmonary embolism (blood clots that form scar-like tissue in the lung's arteries, leading to blockage or narrowing of these arteries) and seizure disorder (is a condition where someone experiences recurring seizures, which are sudden bursts of abnormal electrical activity in brain that can cause temporary changes in behavior). Record review of Resident # 392's admission MDS dated [DATE] indicate a BIMS score 09 reflected moderate cognitive impairment. The MDS indicated that Resident # 392's was totally dependent on two or more staff for bed mobility, transfers, locomotion, dressing, eating, toilet use, and personal hygiene. Review of Resident #392's Physician's Orders dated 02/26/25 reflected the following orders: Had NPO (Nothing per oral) only GT: Flush feeding tube with 30 ml water before and after administration of meds, flush with 10 cc between each medication every shift. Record review of Resident #392's physician's summary order's and MAR had start date of 3/14/25 for the followings medications: 1.FLUoxetine HCl Oral Tablet 20 MG (use to treat depression, and sometimes obsessive compulsive disorder and bulimia) Give 1 tablet via G-Tube one time a day for Depression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Lamotrigine Oral Tablet 25 MG (used to treat partial seizures, primary generalized tonic- clonic, bipolar 1 disorder maintenance and lennox-Gastaut syndrome) Give 1 tablet via G-Tube two times a day for Seizure. 3. Atorvastatin Calcium Oral Tablet 10 MG (a class of medicines used to lower cholesterol) Give 1 tablet via G-Tube one time a day for Hyperlipidemia Observation and interview on 03/19/25 at 8:10 a.m. revealed LVN B was passing medications to Resident #392. During medication pass for Resident # 392, LVN B crushed the following medication. Atorvastatin 10 mg 1 tablet diluted with 5cc of water via G-Tube and was floating in the water. Lamotrigine 25 mg 1 tablet diluted with 5cc of water via G-Tube LVN B attached 60 cc of G-Tube syringe, she checked for placement and instilled 60 cc of water before administering medications. LVN had did not administer all the medication via the syringe, she had medication left in the 2 medicine cups and discarded medication cups, LVN B kept pouring water via the syringe. In an interview with LVN B on 3/19/25 at 8:45 a.m., LVN B said I was trying make sure that the medications were all gone via tubing . LVN B said she forgot to rinse those medication cups and knew Resident #392's not getting all her medication during medication pass, could affect therapeutic drug level in her blood. In an interview with the DON on 3/19/25 at 5:21 p.m., regarding medications LVN B not administering all medication as ordered by the doctor. DON said not administering medication via G-tube in totality as ordered could affect therapeutic level in resident blood. DON said LVN B did not have any orientation on G-Tube, the ADON hired LVN B. ADON should have given LVN B skills orientation on hired . In an interview with ADON on 3/19/25 at 5:56 p.m. she said another RN, who no longer works for the facility was the one that gave LVN B orientation. Record review of LVN B competency skills orientation had hired date on 1/14/2025 and there were no signature on the competency skills orientation performance objectives. Record Review of facility's policy Medication Administration Procedures with revised date of April 2019 revealed . 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5.Medication administration times are determined by resident need and benefit, not staff convenience. Factor that are considered include: a. enhancing optimal therapeutic effect of the medication, b. preventing potential medication or food interactions.