STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676080	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates Arlington Inc	824 W Mayfield Rd Arlington, TX 76015

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44937 Based on interviews and record review, the facility failed to ensure the residents' rights to formulate an advance directive for 2 of 20 residents (Residents #2 and #27) reviewed for advanced directives. The facility failed to ensure Resident #2's and Resident #27's code status was accurate and consistent with all records at the facility. This failure placed the residents at risk of not having their end of life wishes honored. Findings included: Record review of the face sheet dated 06/19/24, reflected Resident #2 was an [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Record review of Resident #2's quarterly MDS, dated [DATE], refleced Resident #2 had a BIMS score of 14, indicating cognition was intact. The assessment indicated Resident #2 required supervision or touching assistance with eating, oral hygiene, toileting, shower/bath, upper and lower dressing, putting on/taking off footwear, and personal hygiene. Active diagnoses included anemia (blood has reduced ability to carry oxygen), coronary artery disease (reduction of blood flow to heart muscle), heart failure (heart's ability to fill with and pump blood), hypertension (high blood pressure), diabetes mellitus (sustained high blood sugar levels), malnutrition (too few or too many nutrients), depression (mental state of low mood), and chronic obstructive pulmonary disease (airflow blockage and breathing-related problems). Record review of Resident #2's undated care plan, revised on 02/18/24, reflected Resident #2 had code status as full code. Goal included to maintain status over the next 90 days. Interventions included code status indicated by green for full code, inform staff of code status, make sure code status was signed by the resident or responsible party, monitor for decrease in change of condition, and report to the physician and the responsible party. Record review of Resident #2's physician order summary report, dated 06/18/24, reflected it did not have an active physician's order for code status: Full Code Status or any other order to support her advanced directive. (continued on next page)

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 - Some	Record review of the face sheet dated 06/19/24, reflected Resident #27 was an [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Record review of Resident #27's quarterly MDS dated [DATE], reflected Resident #27 had a BIMS score of 10, indicating cognition was intact. The assessment indicated Resident #27 required supervision or touching assistance with eating and oral hygiene, partial/moderate assistance with toileting, shower/bath, upper and lower dressing, putting on/taking off footwear, and personal hygiene. Active diagnoses included cancer, hypertension (high blood pressure), diabetes mellitus (sustained high blood sugar levels), malnutrition (too few or too many nutrients), depression (mental state of low mood), and immunodeficiency (failure of the immune system to protect the body adequately form infection). Record review of Resident #27's care plan reflected Resident #27 had code status as Do Not Resuscitate. Goal included to maintain status over the next 90 days. Interventions included code status indicated by red for DNR, inform staff of code status, make sure code status was signed by the resident or responsible party, monitor for decrease in change of condition, and report to the physician and the responsible party. Record review of Resident #27's physician order summary report, dated 06/18/24, did not indicate an active physician's order for code status. During an interview 06/19/24 at 3:14 PM, the Social Worker stated both Resident #2 and Resident #27 readmitted prior to her employment. The Social Worker revealed she had been assisting where she could with medical records. The Social Worker stated she reviewed the advance directive at admission with the resident or the responsible party. The Social Worker stated not having an advance directive placed residents at risk of not having their wishes honored. During an interview of 06/19/24 at 3:17 PM, LVN G stated she was not aware Resident #2's electronic health record did not include an advance directive order. LVN G revealed inside Resident #2's clinical chart at the nursing station indicated Resident #2 was full code. LVN G stated if there was a situation, she would go by the paper chart, and follow the facility protocol based on her paper documentation. LVN G stated advanced directives were discussed and signed at admission. LVN G stated the ADON would review the advance directive and ensure the order was entered. LVN G stated, Resident's electronic health record should match their paper chart so that we could honor resident wishes. During an interview on 06/19/24 at 3:25 PM, the ADON stated when residents admit to the facility, the resident or responsible party provided the advance directive. The ADON stated nursing staff were to keep up with resident advanced directives throughout their facility stay. The ADON stated advance directives were kept in resident charts at the nursing station and in the electric health records. The ADON stated she was not aware there were no orders in place for Resident #2 and Resident #27's advance directive. The ADON stated although all residents were full code unless a do not resuscitate order was in place, there should have been an order to match the paper clinical records. The ADON stated not having an order in place placed residents at risk of not having their life saving measures in place. She stated staff would not know what to do to honor their request. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/20/24 at 4:20 PM, the DON stated she expected advance directive orders to be in place at admission to the facility. The DON stated she and the ADON's were responsible for ensuring orders were in place by reviewing orders after admission. The DON stated the admission nurses enter the orders which would include the resident's advance directives. She stated the ADON reviewed them, and the DON went in to ensure the triggers were activated. The DON stated she guessed the orders were missed upon their last re-admission to the facility. The DON stated not having an order can compromise staff honoring resident lifesaving wishes. Record review of the facility undated admission packet reflected: Policy Statement Regarding Self Determination and Advance Directives. The facility will provide all residents and or their responsible party, at the time of admission, with information relating to the resident's right to accept or refuse medical treatment, and the right to formulate advance directives. The facility will follow physician's orders reflecting such rights Record review of facility policy titled Advance Directive revised December 2016 reflected: .Advance Directives will be respected will be respected in accordance with state law and facility policy. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, or family, or legal representative, about the existence of any written advance directive. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Nursing staff will document in the medical record the offer to assist and the president's decision to accept or decline assistance. The attending physician will provide information to the resident and legal representative regarding the president's health status, treatment options, and expected outcomes during the development of the initial comprehensive assessment and care plan

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42859 Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, mental, and psychosocial needs in order attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 5 residents (Residents #27, #39, and #52) reviewed for care plans. 1. The facility failed to create a care plan addressing Resident #27's Apixaban Oral Tablet 2.5 mg. 2. The facility failed to create a care plan addressing Resident #39's Foley catheter. 3. The facility failed to create a care plan addressing Resident #52's Mirtazapine Oral Tablet 15 mg, Donepezil Hydrochloride Oral Tablet 10 mg, and Seroquel Oral Tablet 25 mg (Quetiapine Fumarate). These failures could affect residents by placing them at risk for not receiving care and services to meet their needs. Findings included: 1. Record Review of Resident #27's admission record dated 06/19/24, reflected the resident was an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record Review of Resident #27's quarterly MDS, dated [DATE], reflected she had a BIMS score of 10, indicating moderate cognitive impairment. Further review revealed she had active diagnoses of unspecified dementia (memory loss) unspecified fracture of shaft of right tibia (fracture of the right leg), malignant neoplasm of the neck, face, and head (cancer), hyperlipidemia (high levels of fat particles in the blood), and hypertension (force of blood against the artery walls is too high). Record review or Resident #27's orders dated 06/20/24 reflected it did not address her Apixaban Oral Tablet 2.5 mg order which was prescribed to prevent and treat blood clots and strokes due to her diagnosis of hyperlipidemia. Record Review of Resident #27's care plan dated 06/19/24 reflected it did not address her Apixaban Oral Tablet 2.5 mg order which was prescribed to prevent and treat blood clots and strokes due to her diagnosis of hyperlipidemia. 2. Review of Resident #39's admission record, dated 06/19/24, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #39's quarterly MDS assessment, dated 05/09/24, reflected he had a BIMS score of 0, indicating severe cognitive impairment. Further review revealed he had active diagnoses of obstructive uropathy (a condition in which the flow of urine is blocked), aphasia (a brain disorder where a person has trouble speaking or understanding other people speaking), retention of urine, and he had an indwelling catheter. Review of Resident #39's care plan dated 02/04/24 reflected it did not address his Foley catheter. Review of Resident #39's physician's orders dated 05/28/24 revealed change (Size) French Foley catheter every night shift starting on the 28th and ending on the 28th every month for patency and as needed for leakage or malfunction. There was no size for the Foley catheter. 3. Record review of Resident #52's admission record, dated 06/19/24, reflected the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE]. Record review of Resident #52's quarterly MDS, dated [DATE], reflected the resident could not be understood so she was not able to have a BIMS test, or score recorded. Further review revealed the resident had progressive neurological conditions, coronary artery disease (buildup of plaque in the heart's major blood vessels), hypertension (force of blood against the artery walls is too high), Alzheimer's disease (disease that destroys memory and other important mental functions), and depression (lowering of a person's mood). Record review of Resident #52's care plan dated 06/19/24 reflected the care plan did not address the resident's current medication orders of Mirtazapine Oral Tablet 15 mg for apatite stimulant, Donepezil Hydrochloride Oral Tablet 10 mg for Alzheimer's disease and Seroquel Oral Tablet 25 mg (Quetiapine Fumarate) for vascular dementia to be taken daily. Observation and attempted interview on 06/18/24 at 1:25 PM with Resident #39 revealed he could hear but was unable to speak or answer questions. Resident #39 was observed in the emergency unit at the hospital, and he did not have a Foley catheter. Interview via telephone on 06/20/24 at 4:01 PM with the MDS Coordinator revealed she was responsible for completing care plans by reviewing the residents' orders. The MDS Coordinator also stated that the admission nurse is responsible for inputting the orders for the resident upon admission. The MDS Coordinator said the purpose of the care plan was to ensure all staff knew how to care for each resident at the facility. She stated the it could affect the continuity of care for residents if the care plans were not updated and complete. The MDS Coordinator said the facility DON was ultimately responsible for updating the care plans. Interview on 06/20/24 at 5:46 PM with the DON revealed the MDS Coordinator was not at the facility during the survey period. The DON stated it was the responsibility of the MDS Coordinator, the interdisciplinary team, and herself to update the care plans. The DON said the IDT was responsible for initiating care plans according to their disciplines. The DON stated she and the MDS followed up to ensure the care plans were updated. The DON said the purpose of the care plan was for the continuity of care. The DON said the entire IDT team was responsible for care plans and the MDS Coordinator had done trainings. The DON was asked for the in-service training records, but they were not provided. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Care Planning - Interdisciplinary Team policy, revised September 2013, reflected: Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized. .2. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/ Interdisciplinary Team which includes, [NAME] is not necessarily limited to the following personnel: a. The resident's Attending Physician. b. The Registered Nurse who has responsibility for the resident. c. The Dietary Manager/Dietitian. d. The Social Services Worker responsible for the resident. e. The Activity Director/Coordinator. f. Therapists (speech, occupational, recreational, etc.), as applicable. g. Consultants (as appropriate). h. The Director of Nursing (as applicable). i. The Charge Nurse responsible for resident care. j. Nursing assistants responsible for the resident's care and k. Others as appropriate or necessary to meet the needs of the resident 48236

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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** 44937 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain proper incontinent care for 1 of 5 residents (Resident #26) for activities of daily living care. The facility failed to provide proper incontinence care to Residents #26 without using multiple briefs every 2 hours and as needed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included: Review of Resident #26's face sheet, dated 04/21/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #26's MDS Quarterly Assessment, dated 05/28/24, reflected a BIMS score of 0, which indicated severe cognitive impairment. Further review reflected Resident #2 required total dependence on staff regarding activities of daily living. Review of Resident #26's diagnosis reflected urinary tract infection (an infection in any part of the urinary system), pressure ulcer of the sacral area (localized damage tothe skin and underlying soft tissue at the base of the spine), sepsis (the body's extreme and life-threatening response to an infection), benign prostatic hyperplasia with lower urinary tract symptoms (enlargemet in the size of the prostate gland), neuromuscular disfunction of bladder (when the relationship between the nervous system and bladder function is disrupted by disease or injury). Review of Resident #26's care plan reflected the following: Resident incontinent of the bladder and bowel with the use of briefs, Goal: Resident will not have any skin breakdown over the next 90 days .Intervention: monitor for incontinent care every two hours and as needed, change promptly - cleanse and apply barrier cream .Resident activity of daily living included toileting with 1-2 person assist. Goal: will maintain a sense of dignity by being clean, dry, odor free, and well groomed. Interventions: assist with toileting and peri care. Observation and interview on 06/20/24 at 1:40 PM with LVN C revealed Resident #26 had on two incontinence briefs. Interview with LVN C revealed aides were responsible for incontinence care for Resident #26 every two hours. LVN C stated she assisted if needed. LVN C stated she was aware Resident #2 required an extra brief because of the amount of urine he produced. LVN C stated it was not protocol to use more than one brief; however, exceptions were made for Resident #26. LVN C stated having more than one brief could cause skin breakdown and irritation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/20/24 at 1:57 PM with CNA I revealed she was aware Resident #26 had more than one brief on. According to CNA I, Resident #26 heavily urinated and with the position of his penis, the urine would travel upward, and soak at his sacrum. CNA I stated she had been questioned about his incontinence care several times because it would appear as if she never changed him. CNA I stated it was her idea to put two briefs on the resident, so that it would give extra padding to prevent urine from traveling down around his pressure wound. CNA I stated the ADON and the DON was aware of the method she was using and had not instructed her to discontinue. CNA I stated since they had started putting two briefs on Resident #26, there had not been any more complaints of the resident appearing wet or soiled. CNA stated double briefing could cause skin breakdown. Interview on 06/20/24 at 02:42 PM with the ADON revealed she was aware staff was using more than one brief while completing incontinence care with Resident #26. The ADON stated she had been notified Resident #26 was often wet with shift change, so she went to observe him. The ADON stated she questioned staff after seeing the double briefs. She stated the staff explained urine would travel up, so that was why they were putting two briefs on the resident. The ADON stated everything would be wet around the resident's waist, so this would protect urine from coming up on him and settling around his wound. The ADON stated interventions in place were more frequent rounds. The ADON stated she knew applying multiple briefs were not facility protocol, and it would place residents at risk of skin breakdown and infection. Interview on 06/20/24 at 5:54 PM with the DON revealed aides, nursing, and anyone doing direct care on the residents were responsible to provide adequate incontinence care for residents. The DON stated Resident #26 had a wound on his sacrum. The DON stated she was made aware of Resident #26's double brief which should be in the front area to prevent urine from settling down near his wound. According to the DON, aides revealed the reason for the double briefing was due to the resident's clothing getting wet all the time. The DON stated the thought process included preventing skin breakdown or pressure sores. She stated if it was done with good intentions, it would be a benefit. The DON stated Resident #26 had an air mattress and was being turned every two hours with frequent incontinence care checks. The DON stated it was usually not okay to use this method. She stated if the family found another means of keeping moisture off the resident's private areas, they would be open to trying the suggestion. The DON stated this method placed Resident #26 at risk of having dignity concerns and the collection of urine could cause more skin breakdown. The DON provided several policies but did not provide a policy specific to pericare, briefing procedures, or care with incontinent residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 5 residents (Resident #2) reviewed for oxygen. 1. The facility failed to have physician orders for Resident #2's oxygen use. 2. The facility failed to ensure Resident #2's humidifier and nasal cannula was changed out on a weekly basis. This failure could place residents who received oxygen therapy at risk for inadequate or inappropriate amounts of oxygen delivery and possible infection. Findings included: Record review of Resident #2's face sheet dated 06/19/24, reflected the resident was an [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Record review of Resident #2's MDS dated [DATE], reflected the resident had a BIMS score of 14, indicating cognition was intact. The assessment indicated Resident #2 required supervision or touching assistance with eating, oral hygiene, toileting, shower/bath, upper and lower dressing, putting on/taking off footwear, and personal hygiene. Active diagnoses included anemia (blood has reduced ability to carry oxygen), coronary artery disease (reduction of blood flow to heart muscle), heart failure (heart's ability to fill with and pump blood), hypertension (high blood pressure), diabetes mellitus (sustained high blood sugar levels), malnutrition (too few or too many nutrients), depression (mental state of low mood), and chronic obstructive pulmonary disease (airflow blockage and breathing-related problems). Resident #2's MDS did not indicate required use of oxygen therapy. Record review of Resident #2's care plan reflected Resident #2 was at risk of shortness of breath, edema, chest pain, elevated blood pressure, related to chronic obstructive pulmonary disease. Goals included: Resident will be free of complications of shortness of breath and increased edema. Interventions included: oxygen as ordered. Record review of Resident #2's physician order summary report, dated 06/18/24, reflected there was not an active physician's order for oxygen use. Record review of Resident #2's progress notes dated 06/06/24 at 9:25 PM written by LVN reflected: progress notes: Resident had an episode of syncope in the beauty shop when the hairstylist was doing her hair. This writer went their resident was rush to her room transferred safely back to bed. Resident vital signs were stable except 02 sat noted at 89. Residents open her eyes and was responding 02 sat went up to 95% on 3 liters per minute via nasal cannula. Resident is stable no s/s of discomfort or respiratory distress noted, denied any discomfort. Daughter notified. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 06/18/24 at 3:44 PM revealed an oxygen humidifier bottle with tape, but the date was not legible. Observation of the nasal canula revealed it was not dated and appeared discolored. Oxygen level indicated Resident #2 was provided with 3 liters. Interview with Resident #2 revealed she had been on continuous use of oxygen for some time now. Resident #2 stated a nurse entered her room today to add water to humidifier bottle, but it had been a long while since she had her nasal canula changed. Resident #2 stated it had been over several weeks since she received a cannula replacement. Resident #2 stated she required the use of oxygen at all times, especially while she was up out of bed. Observation and interview on 06/19/24 at 2:21 PM with LVN C revealed Resident #2 had been with oxygen use continuous for a long while now. LVN C stated she was not aware there was no order for Resident #2's oxygen use. LVN C stated it was the admitting nurse's responsibility to ensure all orders were entered to care properly for residents. LVN C stated Resident #2's humidifier and nasal canula should be changed out every Sunday on the 10:00 PM-6:00 AM shift by the charge nurse. LVN C stated Resident #2 had not told her that the canula had not been changed. LVN C stated she was not aware the date was not provided on the oxygen nasal cannula or clear writing on the humidifier bottle. LVN C stated dates were provided to indicate when the task was last done. LVN C stated not providing fresh water or new nasal cannula would cause Resident #2 to be at risk for infection or respiratory concerns. Observation and interview on 06/19/24 at 3:25 PM with the ADON revealed Resident #2 went to the hospital about two months ago and at that time all her orders were discontinued. The ADON stated once Resident #2 returned the admitting nurse should have entered new orders. The ADON stated she was then responsible for reviewing the orders to ensure they were all entered and correct. The ADON stated the oxygen nasal cannula was to be changed out on Sundays, on the overnight shift, by the nurse. The ADON stated she was not aware her chord had not been changed or that there was not a physician order. The ADON stated she expected for nursing staff to ensure they were following physician orders when administering care and treatments. If there was no order, nurses should contact the doctor to get an order. The ADON stated she expected nursing staff to ensure they were changing the nasal cannula and humidifier bottle weekly to prevent risk of the cannula clogging, preventing the proper amount of oxygen flow. The ADON revealed Resident #2 should be on 2 liters of oxygen; however, observation revealed Resident #2 was receiving 3 liters. Interview on 04/20/24 at 4:20 PM with the DON revealed she was not aware there were no orders regarding Resident #2's oxygen use. The DON stated admitting nurses have authority to contact the physician or their Nurse Practitioners to get an order for oxygen. The DON stated not contacting the physician for an order placed the resident at risk of care not being completed properly, staff will not know what to do. The DON stated the humidifier and nasal cannula should be changed out every Sunday once a week by the 10:00 PM-6:00 AM nursing staff, not doing so would increase respiratory illness and infection. A policy on oxygen/respiratory treatment was requested on 06/20/24 at 11:17 AM; however, the policy was not provided prior to exit. The facility also failed to provide a policy on following physician orders.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on two of four medication carts (Hall C) and (Hall D) and 2 of 6 (Resident #46 and #47) reviewed for pharmacy services. The facility failed to ensure the Hall C and Hall D nurses medication carts contained accurate narcotic logs for Residents #46 and #47. LVN B and LVN C failed to document the administration of narcotic medications in a correct and timely manner. These failures could place residents at risk for medication error, drug diversion, and delay in medication administration. Findings included: Review of Resident# 46's Quarterly MDS assessment, dated 06/16/24, reflected the resident was [AGE] year-old female admitted to the facility on [DATE] and a re-admission of 06/10/24, with diagnoses that included hip and knee replacement. Resident #46's had intact cognition with a BIMS score of 13. She was also getting pain medication as needed. Review of Resident #46's physician's orders dated 06/11/24 reflected Tylenol with Codeine #3 Oral Tablet 300-30 MG (Acetaminophen w/ Codeine). Give 1 tablet by mouth every 6 hours as needed for Pain. Review of Resident # 46's Medication Administration Record reflected last administration was on 06/19/24 at 6:30 AM. Review of Resident# 47's Quarterly MDS assessment, dated 04/09/24, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included hip and knee replacement. Resident #46 had intact cognition with a BIMS score of 15. He was also getting scheduled pain medications. Review of Resident #47's physician's orders dated 07/18/23 reflected Tramadol HCl (hydrochloride) Oral Tablet 50 MG . Give 1 tablet by mouth four times daily routinely for Pain. Review of Resident # 47's Medication Administration Record reflected the last administration was on 6/19/24 at 11:00AM. Observation on 06/19/24 at 08:50 AM of the nurses' medication cart for hall C and the Narcotic Administration Record, with LVN B, reflected the following information: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #46's Narcotic Administration Record sheet for Acetaminophen-codeine #3 was last signed off on 06/16/24 for a one-tablet dose given at 09:30 PM, for a total of 97 pills remaining while the blister pack count was 96 pills. Interview with LVN B on 06/19/24 at 09:20 AM, revealed at first she admitted having administered the pain pill and later stated it was administered by the night shift nurse. LVN B stated it was nurses' responsibility to log narcotics after administering. She stated the risk of not logging narcotics after administration could lead to drug diversion, overdose, and discrepancy. LVN B stated she had done in-service on medication administration and narcotic log. Observation on 06/19/24 at 01:31 PM of the nurses' medication cart for Hall D and the Narcotic Administration Record, with LVN C, reflected the following information: Resident #47's Narcotic Administration Record sheet for Tramadol 50mgs was last signed off on 06/16/24 for a one-tablet dose given at 8:00AM, for a total of 38 pills remaining while the blister pack count was 37 pills. Interview with LVN C on 06/19/24 at 1:42 PM revealed she administered Tramadol 50 mg 1 tablet to Resident #47 and had not signed off on the NAR. She stated she gave the resident the medication, but she forgot to sign off on the narcotic administration log. She stated she knew she was to sign-out on the narcotic count sheet after administration, but she did not because she got busy. She said she was not sure what would happen if the narcotics were not being logged off immediately after administration. Interview with the ADON on 06/19/24 at 1:48 PM revealed her expectation was for nurses to log narcotics as soon as possible after administration. She stated after the nurse reported to her, she checked and found out that both the night and the morning shift nurses did not count the narcotics during shift change. She stated Resident #46 was administered pain medication on 6/19/24 at night. She stated her expectation was that nurses should count during shift change and report any discrepancies to her. She stated it was her responsibility to check the cart and ensure the nurses were documenting narcotic administration, but she could not recall the last time she checked the carts. She stated she had done in-services with staff on medication administration, counting of narcotics, and logging off on 01/08/24, 03/10/24, and 03/11/24. Interview with LVN B on 06/19/24 at 2:38 PM revealed she did not count the narcotics with the outgoing nurse. She stated she knew she was supposed to count before she took the key from the night shift, but she did not because after report the night shift nurse was busy on the floor giving report to another nurse. LVN B stated the risk of not counting between the shifts could lead to medication diversion. She stated she had done training on counting before handing over the key. Interview on 06/19/24 at 4:42 PM, the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the Medication Administration Record and to sign on the narcotic log. The DON stated she talked to both nurses and they revealed they did not count during shift change. She stated the DONs were supposed to be checking on the nurse's carts. She stated she had done an in-service regarding key handling and the nurses were aware they cannot leave the facility before counting. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LVN D on 06/20/24 at 2:23 PM revealed she did not count with day shift nurse because she had a family member that was sick. She stated she knew she was supposed to count before handing over the key. She stated she administered the pain medication, and she knew she was supposed to log the medication off after administering, but she got distracted. LVN D stated she knew she was supposed to count to ensure the count was right and failure to count could lead to narcotics missing and diversion. She stated she had done training on counting before handing over the key. Review of the facility's Medication-Controlled Substances policy revised on December 2012 reflected: .9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make sure they count together. They must document and report any discrepancies to the DON .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review the facility failed to ensure the medication error rate was not five percent (5%) or greater for one of three staff (LVN A) which resulted in an 8.57% medication error rate after 35 opportunities with 3 errors for 1 of 3 residents (Resident #57) reviewed for medications. LVN A failed to flush Resident #57's gastrostomy tube with prescribed amount of water before, between, and after medications, when he administered medication. These failures could place residents at risk of physical and chemical incompatibilities leading to an altered therapeutic response and put residents who received medications via gastrostomy tube at risk for gastronomy tube blockage and medication interaction. Findings included: Record review of Resident #57's entry MDS assessment, dated 05/30/23, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. The assessment reflected the resident cognition was severely impaired with a BIMS score of 0. The resident had diagnoses which included gastronomy status and she had a feeding tube. Review of Resident #57's June 2024 Physician Orders reflected there was no orders for flushing gastrostomy tube with 5-10 ml of free water between each medication administration but reflected an order dated 5/29/24 to every shift Flush G-tube with 60ml of water before and after medication administration. Observation on 06/19/24 at 1:00 PM revealed LVN A prepared Carbidopa 25-100 1 tablet (treats Parkinson), Liothyronine 5 mcg 1 tablet (treat hypothyroidism, a condition wherein the thyroid gland does not produce enough thyroid hormone), and Metoclopramide 5 mg 1 tablet (for ulcers), and put the medication in different cups. LVN A crushed the medication, put it in separate cups, and went to Resident #57's room. LVN A washed hands and put on gloves and he positioned Resident #57 in an upright position. LVN A checked for the gastrostomy tube placement and failed to check for residual. He flushed the gastrostomy tube with 30 ml of water, administered medication one at a time, but he did not flush the gastrostomy tube with water between medications. LVN A flushed the gastrostomy tube with 60 ml of water after medications and the administered the 200 ml water as scheduled. Interview with LVN A on 06/19/24 at 1:11 PM revealed he was aware of flushing the gastrostomy tube with water before, between, and after medication administration through the gastrostomy tube for Resident #57. He stated he did not flush because he did not have orders. He stated it was his responsibility and best nursing standard of practice to check the orders before administration of any medication, but he had been flushing at the beginning and at the end of administration. LVN A stated failure to flush between medication administration could lead to the gastrostomy tube having blockage and medication interactions. He stated he had received training on medication administration via gastrostomy tube. He stated he did not contact the doctor because there was an order to flush before and after with 60 ml. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 06/19/24 at 4:34 PM revealed her expectation was for the nurses to flush the gastrostomy tube before, between, and after each medication administration as per the doctor's orders and follow the facility policy. She stated failure to check orders to flush the gastrostomy tube may lead to gastrostomy tube being clogged and medication interaction. The DON stated he had trained the nurses on medication administration via gastrostomy tubes, she had done competency for skills on all staff, but no documentation was provided. She stated it was the ADON's responsibility to follow up on nurses to ensure they have orders in the MAR. Interview with ADON H on 06/20/24 at 10:37 AM revealed she was notified by LVN A he did not flush with 5-10 ml of water between the medications through the gastronomy. She stated she educated LVN A, checked on physician orders, and they were missing orders to flush between the medications. She stated she called the doctor and she has updated the orders. ADON H stated it was her responsibility to audit the charts weekly. She stated she audited the charts but not on gastronomy orders. ADON H stated her expectation was the staff should follow the physician orders and flushing was the best practice with or not having orders. She stated failure to check orders to flush the gastrostomy tube may lead to gastrostomy tube being clogged and medication interaction. Record review of the facility's current Administering Medication through an enteral tube policy revised March 2015, reflected the following: .1 .verify there is a physician order for the procedure. 20 .Check gastric residual volume to assess for tolerance of enteral feeding. .26 .If administering more than one medication flush with 15mls (or prescribed amount) warm sterile purified water between medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable when applicable for 1 of 3 medication carts (Hall C medication cart) and failed to ensured all drugs and biologicals were stored securely for 1 of 5 residents (Resident #2) observed for medication storage. 1. The facility failed to ensure the medication cart for Hall C did not have the following expired medication: 1 bottle Naloxone tablets (used to rapidly reverses an opioid overdose), Sodium chloride ophthalmic solution (used to reduce swelling of the surface of the eye), Aspirin 81 mg (used to prevent heart attack or stroke), Zinc sulfate 220 mg capsules (used to treat or prevent low levels of zinc), Debrox ear drops (for wax removal) and Lispro insulin (used for diabetes). 2. Resident #2 had 1 bottle of eye drops stored at the resident's bedside table not locked in a lock box or secured in the medication cart or medication room. Findings included: Observation on 06/19/24 at 08:50 AM revealed the medication cart for Hall C had the following: - 1 bottle Naloxone tablets with expiry date of 03/05/24, - Sodium chloride ophthalmic solution with expiry date of 03/24, - Aspirin 81 mg expiry 05/24, - Zinc sulfate 220 mg capsules with expiry date of 12/23, - Debrox ear drops with expiry date 04/24 and - Lispro insulin with open date 04/01/24. Interview on 06/19/24 at 9:20 AM LVN B stated it was all nurses' responsibility to ensure expired medications are removed from the cart and put on destruction boxes. She stated she was expected to check the cart each shift, but she did not check. LVN B started the insulin vial was supposed to be discarded after 28 days or when it was discontinued. LVN B stated the outcome for administering expired medications would be that the medication would not be as effective. Interview on 06/19/24 at 2:05 PM with the ADON revealed it was her responsibility to follow behind the nurses and check the carts for expired medications. She stated her expectation was nurses to check their carts ecah shift for expired medications. She stated the risk of administering expired medications would be that the medication will not be effective. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/19/24 at 4:42 PM with the DON revealed her expectation was for all nurses to check the medication carts every shift for labelling and removal of the expired medications. She stated the risk of administering expired medications would be that the medication would not be potent. She stated the ADONs were responsible of checking carts after the nurses. She stated she had done training regarding expired medication removal and cleaning of the carts on 01/08/24. 2. Observation on 06/18/24 at 3:44 PM revealed a bottle of eye drops sitting on Resident #2's bedside table Record review of Resident #2's Face Sheet dated 06/19/24, reflected the resident was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Record review of Resident #2's quarterly MDS dated [DATE], reflected Resident #2 had a BIMS score of 14, indicating cognition was intact. The assessment indicated Resident #2 required supervision or touching assistance with eating, oral hygiene, toileting, shower/bath, upper and lower dressing, putting on/taking off footwear, and personal hygiene. Active diagnoses included Anemia (blood has reduced ability to carry oxygen), Coronary Artery Disease (reduction of blood flow to heart muscle), Heart Failure (heart's ability to fill with and pump blood), Hypertension (high blood pressure), Diabetes Mellitus (sustained high blood sugar levels), Malnutrition (too few or too many nutrients), Depression (mental state of low mood), Chronic Obstructive Pulmonary Disease (airflow blockage and breathing-related problems). Resident #2's MDS indicated use of corrective lenses, with adequate ability to see in adequate light. Record review of Resident #2's care plan, reflected Resident #2 had impaired visual function related to Diabetes. Goal included to show no decline in visual function and ensure appropriate visual aids - Glasses are available to support resident's participation in activities. Interventions included regular visits by mobile vision care, monitor/document/report sudden visual loss, pupils dilated, gray or milky, complaint of halos around lights, double vision, tunnel vision, blurred or hazy vision. Record review of Resident #2's physician order summary report, dated 06/18/24 reflected: Refresh Liquigel Ophthalmic Gel 1 % (Carboxymethylcellulose Sodium) Instill 1 drop in both eyes every 8 hours as needed for analgesics Active 7/17/2023 3:15PM start 7/17/2023 Record review of Resident #2's Medication Administration Record dated 05/01/24-06/18/24 reflected Resident #2's order was as needed, and had not been administered any eyedrops. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/18/24 at 4:34 PM with the ADON revealed she entered Resident #2's room to remove the eyedrops, but Resident #2 refused. According to the ADON, Resident #2 once had orders to allow eyedrops at her bedside. Upon her return from the hospital, it appeared the order was no longer there. The ADON stated she would contact the physician for an appropriate order. The ADON stated upon returning from the hospital physician orders were to be entered by the admitting nurse. The ADON stated she was responsible for ensuring all orders were entered, not doing so would place residents at risk with their care. The ADON stated having medications at the bedside placed residents at risk for over medicating, improper administration, and other residents having access to the medication. Interview on 06/18/24 at 4:37 PM with LVN G revealed she was not aware of the eye drops at Resident #2's bedside table. LVN G stated Resident #2 had an order for eyedrops on the nurse cart to be administered. LVN G stated Resident #2's family had personal items and believed that was where the eyedrops came from. According to LVN G, this failure placed residents at risk of using more than prescribed. LVN G stated all nursing staff were responsible for ensuring all medications were properly stored. Interview on 04/20/24 at 4:20 PM with the DON revealed she was not aware Resident #2 was storing eyedrops at her bedside without an order. The DON stated she expected nursing staff to have appropriate orders for each resident. The DON stated in this case, not having proper order would indicate she did not have eyedrops at her bedside, which could cause over dosing. The DON stated nursing staff are to be observant of resident items and secure anything that could present potential harm. Record review of the facility's Discontinued Medications policy, dated January 2023, reflected the following: "1. if prescriber discontinue a medication, the medication container is removed from the medication cart according to state federal regulations in a timely manner . 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. .8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 44937

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, intervies, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation. The facility failed to ensure sanitary practices were maintained in the kitchen as the dish machine was not performing at the optimal sanitation rate due to having no chlorine and the test strips being used were both expired and the wrong type. These failures could place resident who ate from the kitchen at risk for cross-contamination and food-borne illnesses. Findings included: Observation on [DATE] at 9:30 AM revealed the dishwashing machine had a data plate that read Required: 50 ppm chlorine and Washer Rinse Temperature 120 degrees Minimum. Observation and interview on [DATE] at 9:35 AM of the kitchen revealed Dietary Aide E attempted to run the dish machine. Dietary Aide E then with assistance of Dietary Aide F used testing strips, which they stated they had regularly been utilizing, to test the dish machine's chlorine level. The test revealed a slight change in color only. Both Dietary Aide E and Dietary Aide F observed the chlorine container was empty. Dietary Aide F contacted maintenance to change the large container of chlorine because she stated she could not lift the container by herself. Dietary Aide F stated the procedure was to report to maintenance when the chlorine was out and needed to be changed because the staff could not lift the heavy containers of chlorine. Observation and interview on [DATE] at 11:30 AM with Dietary Aide F revealed when the chlorine was tested again after the new chlorine was changed and added, the test strip continued to have an only slight change in color. When Dietary Aide F was asked to turn the chlorine testing strips over to view the expiration date after viewing the ppm of the chlorine testing strips, the test strips expiration date was [DATE] and the ppm range first increment was 100 million. The dish machine ppm requirement was 50. When asked who Dietary Aide F should notify that the testing strips were expired, she stated her manager. Dietary Aide F also stated she had never looked at the expiration date before and had no knowledge or been trained to check testing strips expiration dates. Dietary Aide F stated using expired test strips meant that the ppm of chlorine was possibly incorrect. Dietary Aide F said this could lead to the dishes being improperly sanitized which could lead to residents becoming sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on [DATE] at 11:47 PM with Dietary Manager revealed at that time, Dietary Aide F notified the Dietary Manager the chlorine test strips were expired, and the Dietary Manager attempted to locate another package of test strips. When the Dietary Manager was asked how dishware was sanitized, the Dietary Manager answered, I have no clue. The Dietary Manager located another package of chlorine testing strips, but it was expired with an expiration date of [DATE]. Also, it too was the type of chlorine strip that was to be used in the dish sink, not the dish machine. The dish machine's chlorine test strip's first test increment was 50 ppm. The expired test strip brought out by the Dietary Manager first chlorine test increment was 100 ppm. Again, the Dietary Manager voiced that she did not know what the correct chlorine ppm test strip was supposed to be used and what the correct ppm was suggested on the placard of the dish machine. The Dietary Manager stated she did not know that the testing strips had expiration dates, and that they were supposed to be checked. The Dietary Manager stated the chemical supply company supplied the chlorine testing strips. The Dietary Manager stated it was her responsibility to request new testing strips from the company when they deliver the kitchen's chemicals. Lunch was served using disposables because testing strips that were expired and the correct ppm could not be located before the residents' lunch time. Interview on [DATE] at 1:27 PM with Dietary Aide F revealed Dietary Aide F had worked at the facility for about 6 months. She stated the previous Dishwasher gave her that specific pack of testing strips and told her the color should be somewhere between ,d+[DATE] ppm when she was trained in [DATE]. She said she looked for that color when she tested for chlorine in the mornings before she washed the first load of dishes. Dietary Aide F confirmed it was her responsibility to tell the Dietary Manager the test strips were out of date. When asked what ppm were required per the dish machine specifications, she stated she was unsure. When asked when she should tell her manager that her test strips were expired, the wrong type, or she was out of chlorine, she stated she should tell the Dietary Manager immediately. Dietary Aide F said that residents could get sick if there was not enough chlorine in the machine. Interview on [DATE] at 1:56 PM with [NAME] J revealed she had worked at the facility for more than [AGE] years. She stated whoever used the dish machine was supposed to test for chlorine level before they ran the dishes through it. [NAME] J also stated if there was no chlorine, the test strips were expired, or the test strips were the wrong type. She stated the Dietary Manager was supposed to be notified because that was who was ultimately responsible. She stated she did not use the dish machine because she was the Cook. She also stated the risk to the resident was that the residents could get stomach illnesses, stomach infections, and stomach poisoning, et cetera. Interview on [DATE] at 2:10 PM with Dietary Aide E revealed she had worked at the facility for about six months. Dietary Aide E revealed it was the Dishwasher's responsibility to check for chlorine, type of test strip, and expiration date before starting the first load of dishes. She stated it was their responsibility to inform the Dietary Manager if they ran out of chlorine or chlorine testing strips during their shift. Dietary Aide E stated she was unable to tell if the dish machine was using 50 ppm because the testing strips that were currently being used start at 100 ppm on the testing strips, and they were expired. Dietary Aide E stated she did not report the expired or wrong type of testing strip to the Dietary Manager. Dietary Aide E stated the only training she received was by the previous Dishwasher who trained her on those test strips. Dietary Aide E also added that she was unsure the dish machine had been out of chlorine. Dietary Aide E revealed residents could get sick if the dish machine had no chlorine, the test strips were expired, or it was the wrong type of chlorine testing strips. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 2:33 PM with Dietary Manager revealed she started dietary manager training in [DATE] with online with a university. She also stated it was the Dishwasher's responsibility to check for chlorine before beginning the dishwasher and to test the dish machine for chlorine. The Dietary Manager revealed it was her responsibility to ensure the facility had the correct type of test strips and that the test strips were not expired. The Dietary Manager was unsure how long the expired and wrong type of chlorine strips had been used in the facility and because of this that the dish machine log was probably inaccurate. When she was asked how long she thought the dish machine was without chlorine, the Dietary Manager said that it was about a day. Then Dietary Manager stated residents could get a stomach virus and get sick. Interview on [DATE] at 6:28 PM with the Administrator revealed the Dishwasher should use the proper test strips. The Administrator stated they should run a few cycles after changing and adding chlorine and test it after each meal to ensure that it was running properly. The Dietary Manager was responsible for insuring this was done. The Dietary Manager should tell the Administrator if there was a problem. Improper sanitation was a risk to the resident because it could cause an upset stomach. Record review of the facility's Infection Control/Procedure Departmental Dietary Services policy, dated [DATE], reflected: .The dishwasher should be kept between 140 degrees and 200 degrees F, if using chemical sanitizer, rinse temperature can be 120 degrees F Machine should be maintained and run according to manufacturer's instructions. Review of the U.S. Public Health Service, Food Code (2017) section S,d+[DATE].113(A) reflected: .(B) A WAREWASHING machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine's design and operation specifications including the: Temperatures required for washing, rinsing, and SANITIZING; Pressure required for the [NAME] SANITIZING rinse unless the machine is designed to use only a pumped SANITIZING rinse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676080	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates Arlington Inc	824 W Mayfield Rd Arlington, TX 76015

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on interview and record review, the facility failed to ensure there were physician orders for 2 of 15 residents (Residents #39 and #57) reviewed for physician orders. 1. The facility failed to obtain physician orders for Resident #57 gastrostomy tube flushes between medications. 2. The facility failed to obtain physician orders for Resident #39's urinary catheter, to include the size of the catheter to be used. These failures could place residents at risk of not receiving the appropriate care as ordered by the physician. Findings included: Record review of Resident #57's entry MDS assessment, dated 05/30/23, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. The assessment reflected the resident cognition was severely impaired with a BIMS score of 0. The resident had diagnoses which included gastronomy status and she had a feeding tube. Review of Resident #57's June 2024 Physician Orders reflected there was no orders for flushing gastrostomy tube with 5-10 ml of free water between each medication administration but reflected an order dated 05/29/24 to every shift Flush G-tube with 60ml of water before and after medication administration. Review of Resident #57's care plan dated 05/24/24 reflected: Flush g-tube before and after meds as ordered by physician. Interview with LVN A on 06/19/24 at 1:11 PM revealed he was aware of flushing the gastrostomy tube with water before, between, and after medication administration through gastrostomy tube for Resident #57 but he did not, because he did not have orders. He stated it was his responsibility and best nursing standard of practice to check the orders before administration of any medication, but he has been flushing at the beginning and at the end of administration. LVN A stated failure to flush between medication administration could lead to gastrostomy tube blockage and medication interactions. Interview with the DON on 06/19/24 at 4:34 PM revealed her expectation was for the nurses to flush the gastrostomy tube before, between, and after each medication administration as per the doctor's orders and follow the facility policy. She stated failure to check orders to flush the gastrostomy tube may lead to gastrostomy tube being clogged and medication interaction. The DON stated he had trained the nurses on medication administration via gastrostomy tubes, and she had done competency for skills on all staff., No documentation was provided as requested. She stated it was the ADON's responsibility to follow-up on nurses to ensure they have orders in the MAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with ADON H on 06/20/24 at 10:37 AM revealed she was notified by LVN A he did not flush with 5-10 ml water between the medications through the gastronomy.She stated she educated LVN A, checked on physician orders, and they were missing orders to flush between the medications.She stated she called the doctor, and she has updated the orders. ADON H stated it was her responsibility to audit the charts weekly. She stated she audited the charts on other orders but on gastronomy orders. She stated failure would cause gastronomy tube clogging. 2. Review of Resident #39's admission record dated, 06/19/24, revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. Review of Resident #39's MDS assessment, dated 05/09/24, reflected he had a BIMS score of 0, indicating severe cognitive impairment. Further review revealed he had active diagnoses of obstructive uropathy (is a condition in which the flow of urine is blocked), aphasia (is a brain disorder where a person has trouble speaking or understanding other people speaking), retention of urine, and he had an indwelling catheter. Review of Resident #39's care plan dated 02/04/24 reflected it did not address his Foley catheter. Review of Resident #39's physician's orders dated 05/28/24 revealed change (size) French Foley catheter every night shift starting on the 28th and ending on the 28th every month for patency and as needed for leakage or malfunction. There was no size for the Foley catheter. Review of Resident #39's nursing progress notes reflected the facility was using Foley catheter French size 18. Interview with LVN D on 06/20/24 at 10:06 AM revealed she had not seen the size for the Foley catheter, but she has been inserting a French size 18. She stated the size was left open on the Foley catheter orders, and she had not consulted with the doctor because she thought the size was left out intentionally. She stated she was supposed to confirm the size. She stated the risk of not confirming the size was that if they inserted a bigger size it could harm the resident or if they inserted a smaller size it might cause urine to leak. She stated she had done training on physician orders. Interview with ADON on 06/20/24 at 10:20 AM revealed it was her responsibility to follow-up on admissions and ensure the orders were correct and also when there was a new order. She stated she checked and found out there were orders for a Foley catheter but no specific orders for the size. The risk of not having a physician order for catheter size was that it could lead to leakage or blocking the urine passage. Interview with the DON on 06/20/24 at 10:50 AM revealed her expectation was that the nurses would ensure they had Foley catheter sizes before they inserted a catheter into a resident. She stated the nurses failed to follow-up with the primary physician to get the size from admission. She stated failure to have sizes could cause trauma if they used big sizes or cause leakage if they used small sizes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Physician K on 06/20/24 at 11:33 AM revealed he gave verbal orders to staff in the facility, and his expectation was they were supposed to update the size orders. For gastronomy flushing, Physician K stated those were standard orders that should be documented on any resident receiving medications through gastronomy tube. He stated he could not remember when he gave the verbal orders. He stated failure to use the right size catheter might cause trauma or leakage. Review of the facility's Medication and Treatment Orders policy, revised July 2016, reflected: Verbal orders must be recorded immediately in the resident chart by the person receiving the order and must be include prescriber's last name, credentials, the date, and the time of the order.