STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676083	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsville Nursing and Rehabilitation Center	320 Lorenaly Dr Brownsville, TX 78520

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 45737 Based on interviews, and record review, the facility failed to develop and implement a person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 4 of 4 residents (Resident #1, #2, #3, and #4) reviewed for comprehensive care plans. 1. The facility did not include Resident #1's wound and physician ordered wound care on his care plan. 2. The facility did not include Resident #2's diet and the need for crushed medications on their care plan. 3. The facility did not include Resident #3's diet and the need for crushed medications on their care plan. 4. The facility did not include Resident #2's diet and the need for crushed medications on their care plan. This failure could place residents at risk for not receiving appropriate treatment and services. The findings were: 1. Record review of Resident #1's face sheet, dated 09/12/24, revealed the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: other acute (recent) osteomyelitis (infection of the bone), right ankle and foot, type 2 diabetes mellitus (high blood sugar) without complication, end stage renal disease (when kidneys no longer filter wastes ad fluids from the body), and dependence on renal (kidney) dialysis (blood is removed and filtered and then returned back into body). Record review of Resident #1's admission minimum data set assessment (MDS), dated [DATE], revealed Resident #1 had a BIMS score of 15, indicating the resident was cognitively intact. Resident #1's MDS's revealed Resident #1 had surgical wounds and surgical wound care as treatment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's weekly wound progress note dated 09/09/24 revealed Resident #2 had a surgical incision on his right plantar foot and had an intervention to Apply treatment as ordered by physician checked off. Record review of Resident #1's active physician orders revealed Resident #1 had an order for surgical incision to right plantar foot: cleanse site with wound cleanser, dry with clean gauze, apply Santyl, then apply collagen powder, cover with clean gauze, wrap with rolled gauze, and secure with tape. To be completed daily with a start date of 09/04/24 and indefinite end date. Record review of Resident #1's care plan with an initiated date of 07/24/24 revealed no verbiage regarding Resident #1's wound or wound care. 2. Record review of Resident #2's face sheet, dated 09/12/24, revealed the resident was an [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: dysphagia, oropharyngeal phase (difficulty swallowing food or liquid), type 2 diabetes mellitus (high blood sugar) without complication, unspecified dementia (the loss memory and other thinking abilities that interfere with daily life), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and essential (primary) hypertension (high blood pressure). Record review of Resident #2's admission minimum data set assessment (MDS), dated [DATE], revealed Resident #2 had a BIMS score of 03, indicating the resident was severely cognitively impaired. Resident #2's MDS's revealed Resident #2 was on a mechanically altered diet while a resident. Record review of Resident #2's modified barium swallow study completed on 07/30/24 revealed meal diet recommendations for pureed and thin liquids and a recommended pill strategy that stated, Chocking risk - crush meds. Record review of Resident #2's active physician orders revealed Resident #2 had an order for, NAS (No Added Salt) Diet with instructions of, Pureed texture, Regular Liquids consistency with a start date of 07/24/24. Record review of Resident #2's active physician orders revealed Resident #2 had an order for, May crush medications and/or open capsules PRN as per pharmacy guidelines with an order date of 07/23/24. Record review of Resident #2's care plan with an initiated date of 07/24/24 revealed no verbiage regarding Resident #2's diet or need for crushed medication. 3. Record review of Resident #3's face sheet, dated 09/11/24, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: metabolic encephalopathy (brain dysfunction caused by problems with your metabolism), acute systolic (congestive) heart failure (when the left ventricle of the heart cant pump blood efficiently), pleural effusion (accumulation of excessive fluid in the pleural space, the potential space the surrounds each lung), not elsewhere classified, acute (recent) and chronic (continuing) respiratory failure (damaged airways reduce the amount of oxygen that enters the body and the carbon dioxide that gets out), unspecified whether with hypoxia (low oxygen levels), or hypercapnia (high levels of carbon dioxide). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's admission minimum data set assessment (MDS), dated [DATE], revealed Resident #3 had a BIMS score of 10, indicating the resident was moderately cognitively impaired. Resident #3's MDS's revealed Resident #3 was on a mechanically altered diet while a resident. Record review of Resident #3's miscellaneous documents were reviewed from 08/28/24 until 09/12/24 with no modified barium swallow study identified. Record review of Resident #3's active physician orders revealed Resident #3 had an order for, Regular diet, Pureed texture, Regular Liquids consistency with a start date of 09/10/24 and no end date. Record review of Resident #3's discontinued physician orders revealed Resident #3 had an order for, Regular diet, Pureed texture, Regular Liquids consistency with a start date of 09/06/24 and discontinued date of 09/10/24. Record review of Resident #3's active physician orders on 09/11/24 at 1:13 pm revealed Resident #3 did not have an order for crushed medications. Record review of Resident #3's physician orders revealed Resident #3 had an order for, May crush medications and/or open capsules PRN as per pharmacy guidelines with a start date of 08/31/24 and was discontinued by ADON B on 09/02/24. Record review of Resident #3's active physician orders on 09/12/24 at 10:05 am revealed the facility added an order of, May crush medications and/or open capsules PRN as per pharmacy guidelines on 09/11/24 at 4:1 after Surveyor A intervention. Record review of Resident #3's care plan with an initiated date of 09/02/24 revealed no verbiage regarding Resident #3's diet or need for crushed medication. 4. Record review of Resident #4's face sheet, dated 09/12/24, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: dysphagia, oropharyngeal phase (difficulty swallowing food or liquid), unspecified fracture (break) of left femur (thigh bone), subsequent encounter for closed fracture (break) with routine healing, and essential (primary) hypertension (high blood pressure). Record review of Resident #4's admission minimum data set assessment (MDS), dated [DATE], revealed Resident #4 had a BIMS score of 12, indicating the resident was moderately cognitively impaired. Resident #4's MDS's revealed Resident #4 was on a mechanically altered diet while a resident. Record review of Resident #4's modified barium swallow study completed on 07/30/24 revealed meal diet recommendations of mechanical soft, INITIAL MEAL TRAY WITH SLP, Thin liquids. and a recommended pill strategy that stated, Chocking risk - crush meds. Record review of Resident #4's physician orders revealed Resident #4 had an order for, NAS (No Added Salt) diet, Pureed texture, Regular Liquids consistency with a start date of 08/07/24 and an end date of 08/24/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's physician orders revealed Resident #4 had an order for, May crush medications and/or open capsules PRN as per pharmacy guidelines with a start date of 07/23/24 and was discontinued by ADON B on 09/02/24. Record review of Resident #4's care plan with an initiated date of 07/23/24 revealed no verbiage regarding Resident #4's diet or need for crushed medication. During an interview and record review with MDS C on 09/11/24 at 3:09 pm she stated her and MDS D were responsible for the development of the resident's care plans. MDS C clarified that she would complete the care plans for the long-term side and MDS D would complete the care plans for the skilled side. MDS C stated Residents #1, #2, #3, and #4 were all a part of the skilled side however, MDS D was out on leave at the time of the interview. MDS C stated both long term and skilled residents have their care plans reviewed for accuracy and completion during the MD review, and with any changes or significant changes. MDS C stated residents wounds, wound care, diet, and need for crushed medications should be included on their care plan. MDS C stated it was important for these items to be on the resident's care plan so that all staff would be aware. MDS C reviewed care plans for Resident #1 and confirmed there was no verbiage of his wound or wound care to his right foot. MDS C reviewed the care plan for Resident #2, #3, and #4 and confirmed there was no verbiage regarding their specific diet or need for crushed mediation. MDS C stated the information was not there because MDS D had probably not gotten to it at that time. MDS C stated both her and MDS D had been trained over care plans and received training via an online software every 2 years in order to get certified for RUGS. MDS C stated she did not remember what was on the facility's care plan policy but stated she was aware they had 48 hours to complete a baseline care plan and 14 days for a comprehensive care plan. MDS C did not clarify if the facility policy was followed and only stated, at our best, yes we try. MDS C stated care plans were monitored to ensure accuracy, completion, and that all required resident care specifics had been added by updating them quarterly and as needed, reviewing them during care plan meetings, discussing any changes, and documenting those changes on the care plan. MDS C stated not including residents diet texture, need for crushed medication could negatively impact a resident because they could be given the wrong textured diet and choke. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review with the DON on 09/11/24 at 3:14pm he stated MDS C completed the care plans for the long-term side and MDS D would complete the care plans for the skilled side, but they would help each other. The DON stated he would review the initial care plan on admission and stated the comprehensive care plans would go under the care of the MDS nurse. He stated the MDS nurses were in their clinical meetings and when changes arose, they would make those changes to the care plan. The DON stated residents' wounds, wound care, diet, and need for crushed medications should be included on their care plans. The DON stated it was important for these items to be on the resident's care plan to ensure that they had interventions and goals in place for those residents. He stated care plans had to be individualized for each resident and stated those goals and expectations had to be on there. The DON reviewed the care plan for Resident #1 and confirmed there was no verbiage of his wound or wound care to his right foot. The DON stated he had already reviewed the care plan for Resident #2, #3, and #4 and confirmed there was no verbiage regarding their specific diet or need for crushed mediation. The DON stated he was unable to answer why the information was not present on the resident's care plans but stated it should be and stated MDS D would be responsible for those care plans because those residents were short term. The DON stated both MDS C and MDS D had received frequent training from their regional MDS. The DON stated he didn't have the facility policy regarding care plans on the top of his head, but did know that things such as diets, crushed medications, and skin issues needed to be on the care plan. The DON stated in this situation staff followed the facility policy as much as they could. The DON stated every patient was different and had different needs. He stated they would put interventions in place to meet those needs, and if it was not on their care plan, then the residents' needs would not be taken care of. The DON stated not including a resident's diet texture, need for crushed medication, wounds, and wound care could negatively impact a resident because they won't get the specific care they need. Record review of facility in-service training reports revealed MDS C and MDS D were trained over comprehensive care plans and the policy by the Administrator on 06/28/24. Record review of facility policy titled Comprehensive Care Plans with an implementation date of 10/24/22 included a section titled, Policy Explanation and Compliance Guidelines that included the following verbiage: 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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** 45737 Based on interviews, 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 for 2 of 4 residents (Residents #3 and #4), reviewed for pharmaceutical services. 1. The facility failed to obtain and input orders for crushed medication for Resident #3. 2. The facility failed to obtain and input orders for crushed medication for Resident #4. This failure could place residents at risk of not receiving their medication safely. 1. Record review of Resident #3's face sheet, dated 09/11/24, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: metabolic encephalopathy (brain dysfunction caused by problems with your metabolism), acute systolic (congestive) heart failure (when the left ventricle of the heart cant pump blood efficiently), pleural effusion (accumulation of excessive fluid in the pleural space, the potential space the surrounds each lung), not elsewhere classified, acute (recent) and chronic (continuing) respiratory failure (damaged airways reduce the amount of oxygen that enters the body and the carbon dioxide that gets out), unspecified whether with hypoxia (low oxygen levels), or hypercapnia (high levels of carbon dioxide). Record review of Resident #3's admission minimum data set assessment (MDS), dated [DATE], revealed Resident #3 had a BIMS score of 10, indicating the resident was moderately cognitively impaired. Resident #3's MDS's revealed Resident #3 was on a mechanically altered diet while a resident. Record review of Resident #3's miscellaneous documents were reviewed from 08/28/24 until 09/12/24 with no modified barium swallow study identified. Record review of Resident #3's active physician orders revealed Resident #3 had an order for, Regular diet, Pureed texture, Regular Liquids consistency with a start date of 09/10/24 and no end date. Record review of Resident #3's discontinued physician orders revealed Resident #3 had an order for, Regular diet, Pureed texture, Regular Liquids consistency with a start date of 09/06/24 and discontinued date of 09/10/24. Record review of Resident #3's active physician orders on 09/11/24 at 1:1 revealed Resident #3 did not have an order for crushed medications. Record review of Resident #3's physician orders revealed Resident #3 had an order for, May crush medications and/or open capsules PRN as per pharmacy guidelines with a start date of 08/31/24 and was discontinued by ADON B on 09/02/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's active physician orders on 09/12/24 at 10:05 am revealed the facility added an order of, May crush medications and/or open capsules PRN as per pharmacy guidelines on 09/11/24 at 4:1 after Surveyor A intervention. Record review of Resident #3's care plan with an initiated date of 09/02/24 revealed no verbiage regarding Resident #3's diet or need for crushed medication. 2. Record review of Resident #4's face sheet, dated 09/12/24, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: dysphagia, oropharyngeal phase (difficulty swallowing food or liquid), unspecified fracture (break) of left femur (thigh bone), subsequent encounter for closed fracture (break) with routine healing, and essential (primary) hypertension (high blood pressure). Record review of Resident #4's admission minimum data set assessment (MDS), dated [DATE], revealed Resident #4 had a BIMS score of 12, indicating the resident was moderately cognitively impaired. Resident #4's MDS's revealed Resident #4 was on a mechanically altered diet while a resident. Record review of Resident #4's modified barium swallow study completed on 07/30/24 revealed meal diet recommendations of mechanical soft, INITIAL MEAL TRAY WITH SLP, Thin liquids. and a recommended pill strategy that stated, Chocking risk - crush meds. Record review of Resident #4's physician orders revealed Resident #4 had an order for, NAS (No Added Salt) diet, Pureed texture, Regular Liquids consistency with a start date of 08/07/24 and an end date of 08/24/24. Record review of Resident #4's physician orders revealed Resident #4 had an order for, May crush medications and/or open capsules PRN as per pharmacy guidelines with a start date of 07/23/24 and was discontinued by ADON B on 09/02/24. Record review of Resident #4's care plan with an initiated date of 07/23/24 revealed no verbiage regarding Resident #4's diet or need for crushed medication. During an interview with Resident #3 and his family member on 09/10/24 at 3:5 he stated he was a puree diet with his family member stating they brought him everything in puree form. Resident #3 stated his medication was already crushed when he received them. Resident #3's family member stated they would crush his medication and mix his medication with apple sauce. Resident #3 stated he had not had any problems with his medication. During an interview with Resident #4 on 09/11/24 at 10:33 am she stated her food was pureed and her medication was given to her with some crushed and some not. Resident #4 stated she did not have any problems taking her pills and stated she was okay with them regular because she did not want them crushed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review with MA E on 09/11/24 at 3:5 she stated medication aides were not responsible for and did not have access for inputting orders. She stated she had been going based off the resident's diet in order to identify which residents needed crushed medication. MA E stated if a resident was on puree, then the medication would have to be crushed. MA E stated from what she knew an order for crushed medication should be in place for those who required medications to be crushed. MA E reviewed orders for Resident #3 and #4 and stated there were no orders for crushed medication and both residents should have crushed medications. MA E did not know why there was not an order for crushed medications. MA E stated having orders for crushed medication was important so that residents could take their medication properly and not choke while taking their medication. MA E stated she worked with both Resident #3 and #4 on multiple occasions and had provided both with crushed medications. MA E stated she had not been provided any real training but was aware to go to her charge nurse for any inputting or requests for orders. MA E stated she had not noticed that Residents #3 and #4 did not have orders for crushed medication because she was going based off their diet. MA E stated she was not aware of the facility policy for needing orders for crushed medication. MA E stated she monitored to ensure residents had the accurate and appropriate orders in place by triple checking every time she provided medication and looking through residents' charts for any change to their diet since they used that to go off of. MA E stated not inputting an order for crushed medication could negatively impact the residents because they could possibly choke. During an interview and record review with ADON B on 09/11/24 at 4:8 she stated the nurses were responsible for inputting orders. ADON B stated they had been going based off the resident's diet in order to identify which residents needed crushed medication. ADON B stated they had only ever had batch orders, she had never come across anything that stated they needed to have an order for crushed medication, and stated nursing judgement went based off the residents' diet. ADON B reviewed Resident #3 and #4's charts and stated the diet was there for Resident #3 and that previously (before 09/11/24) there weren't crushed medication orders, but that they were doing that now. ADON B stated Resident #4 was on puree and crushed medication but stated her order was discharged on [DATE]. ADON B stated both residents should have an order for crushed medications. ADON B stated when a resident was admitted they would do batch orders and one of those orders was for may have crushed meds. ADON B stated she was not sure why, but she would get a message that prompted her to confirm or confirm discontinue some orders. ADON B stated she thought somehow, she was prompted to confirm to discontinue Resident #4's order to crush medication, and she stated she thinks that may have been what happened. ADON B stated having orders for crushed medication was important to prevent aspiration and choking. ADON B stated she was not sure how Resident #3 and #4 were being administered their medication. ADON B stated as for staff being trained over requesting orders when needed it, was something that they would just tell staff about verbally. ADON B stated she did not think there was a policy regarding having orders in place for crushed medication, but she would ask the DON for clarification. ADON B stated she monitored to ensure residents had the accurate and appropriate orders in place during care plan meetings where MDS nurses would review medications, changes in conditions, and any new admissions. ADON B stated not inputting an order for crushed medication could negatively impact the residents because they could possibly aspirate or choke. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review with MA F on 09/11/24 at 4:59pm she stated the nurses were responsible for inputting orders. MA F stated she had been going based off the resident's diet in order to identify which residents needed crushed medication. MA F stated if a resident was on puree, then the medication would have to be crushed unless the resident did not want medications crushed. MA F stated there should be orders in place for those who required medications to be crushed. MA F reviewed orders for Resident #3 and #4 and stated there were no orders for crushed medication and stated both residents should have crushed medication orders. MA F did not know why there was not an order for crushed medications for either resident and she had not noticed there weren't orders in place for crushed medication. MA F stated having orders for crushed medication was important so that they could make sure residents could swallow their pills. MA F stated she worked with both Resident #3 and #4, sometimes Resident #3 would want his medications whole, and his family was always there with him. MA F stated Resident #4 was very outspoken and alert and would say she did not want her medication crushed and wanted it whole. MA F stated she had been trained by the DON over requesting orders but could not recall when. MA F stated the facility policy was that they needed orders for crushed medications, and they needed to talk to the nurse about it. MA F stated in this situation she felt she followed the facility policy. MA F stated she monitored to ensure resident had accurate and appropriate orders in place by going over their order. MA F stated not inputting orders for crushed medications could negatively impact a resident because they could choke. During an interview and record review with MA G on 09/12/24 at 1:3 he stated the nurses were responsible for inputting orders. MA G stated he would review a resident's diet to identify which residents needed crushed medications. MA G stated if a resident was on puree, then the medication would have to be crushed. MA G stated there should be orders in place for those who required medications to be crushed. MA G reviewed orders for Resident #3 and #4 and stated for Resident #3 he did not see any order for crushed medication. He stated his diet was puree and that was how he would tell he required crushed medications. MA G stated Resident #3's family was with him 24/7 and the family had been refusing crushed medications and wanted them whole. MA G stated Resident #4 did not have an order for crushed medication, but he was on a puree diet. MA G stated he could not recall working with Resident #4, but stated if she had a puree diet then he would have given them to her crushed. MA G stated if the medications were going to be crushed, he thought there should be an order in place. MA G did not know why there was not an order for crushed medications for either resident and he had not noticed there weren't orders. MA G stated having orders for crushed medication was important because residents could possibly choke. MA G stated he had not been trained over requesting orders but stated it was just apart of his competence to go to the nurse with anything he noticed or with different family/resident requests. MA G reviewed the pharmacy policy and stated the DON had previously provided them training over the policy within the last few months. MA G did not clarify if he followed the policy or did not. He stated based on his understanding, he would give medication based off the diet that's on the MAR. MA G stated he monitored to ensure the resident had accurate and appropriate orders in place by talking to the residents and their family, confirming with the nurse, and getting the SLP involved. MA G stated not inputting orders for crushed medications could negatively impact a resident because they could choke. (continued on next page)

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Brownsville Nursing and Rehabilitation Center	320 Lorenaly Dr Brownsville, TX 78520

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 09/12/24 at 3:2 he stated the admitting nurses or charge nurses were responsible for inputting orders when new orders came in. The DON stated staff used the resident's diet in order to know if residents required their medications to be crushed. He stated if a resident received puree then the med aides knew to crush the medication unless the resident requested otherwise. The DON stated according to their facility policy there should be an order for crushed medications for those who require it. The DON stated he had already reviewed Resident #3 and Resident #4's orders and was making changes. The DON stated prior to today 09/12/24, there were no orders for crushed medication for Resident #3 and #4. He stated they did require it. The DON stated he did not know why the order for crushed medication was not there. The DON stated it was important to have orders for crushed medication specifically in order to know which can and can't be crushed. The DON did not know if Residents #3 and #4 were provided crushed medication. The DON stated staff had been trained over inputting and requesting orders when needed. He stated they had a training on 09/11/24 and February or March on documentation and orders specifically. The DON stated he usually provided those training's. The DON stated as per facility policy if the medication was going to be crushed there needed to be a physician order. The DON stated he did not think staff followed the facility policy in this situation. The DON stated he monitored to ensure residents had the accurate and appropriate orders in place by going medication by medication upon admission and reviewing any new order for long term care residents. The DON stated because they had been going by the resident's diet, they had not had any negative affects due to not having an order for crushed medication. Record review of facility in-service training reports revealed ADON B and MA F were trained over physician orders by the Administrator on 06/28/24. Record review of facility in-service training reports revealed MA E and MA G were trained over physician orders by the Administrator on 06/28/24. Record review of facility policy titled Medication Administration with an implementation date of 10/01/19 included a section titled, Procedure that included the following verbiage: G. Tablet Crushing/Capsule Opening: Crushing tablets may require a physician's order, per facility policy. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines . h. The need for crushing medications is indicated on the resident's orders and the MAR so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety issues and alternatives, if appropriate, during medication regimen reviews.