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	06/27/2024

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40872 Based on observations, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference for two (resident #90 and resident #98) of four residents reviewed for call light. The facility failed to ensure Resident #90 and Resident #98's call lights were within reach. This failure could place residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings were: 1.Record review of Resident #90's Admission record dated 06/27/24 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Muscle Weakness (Generalized), Hemiplegia (one sided weakness) and Hemiparesis (weakness of 1 side of body) following cerebral infraction (stroke) affecting left non-dominant side, and Need for Assistance with personal care. Record Review of Resident #90's Quarterly Care Plan revised 12/19/23 revealed the Resident was at risk for falls r/t impaired mobility, impaired cognition, impaired eliminated An intervention was to be sure call light was within reach and encourage the resident to use it for assistance, as needed. The resident needs prompt response to all requests for assistance. Date initiated 02/24/24 2. Record review of Resident #98's Admission record dated 06/27/24 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of Muscle Weakness (Generalized), Age-Related Physical Debility, Unspecified Atrial Fibrillation (abnormal heart rhythm), Need for Assistance with Personal Care. Record Review of Resident #98's Quarterly Care Plan revised 06/17/24 revealed the Resident was at risk for falls as fall risk score of 7.0 r/t history of fall. An intervention was to be sure the resident's call light was within reach and encourage the resident to use it for assistance, as needed. The resident needs prompt response to all requests for assistance. Observation on 06/24/24 at 9:49 a.m. revealed call light was on the floor behind night stand in Resident #98's room. During an interview on 06/24/24 at 9:50 a.m. Resident #98 said she uses the call light sometimes but staff are usually coming around to see if she needs anything. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/24/24 at 10:05 a.m. revealed call light was on the floor next to Resident #90's bed. During an interview on 06/24/24 at 10:06 a.m. Resident #90 said that she usually did not have trouble finding her call light. She said she cannot get up out of bed on her own and eats in her room. During an interview on 06/24/24 at 10:08 a.m. NA G said the call light must have fallen on the floor. She said she had just picked up the food tray for Resident #90 and must have overlooked the call light on the floor. NA G said if the call lights are not within resident reach, and the resident needs help, they (staff) are not going to know that they need help. She said that they are told by nurses and DON weekly to remember to have resident call lights within reach. During an interview on 06/24/24 at 10:24 a.m. ADON P said that all residents should have call lights within their reach. She said she checks when she does her rounds to make sure they are clipped on the bed. ADON P said if a call light was not within reach, they wont be able to call for assistance and staff wont know that they need help. She said all staff know that the resident must be able to call for help with the call light so they are supposed make sure it was near the resident. During an interview on 06/24/24 at 4:20 p.m. the DON said that all staff have trainings on call lights, both answering and accessing them. The DON said the call light for a resident must be within reach at all times. He said the staff need to attend in a timely manner and in case of an emergency, this was why they need to be easily accessed by residents. Record review of facility's policy titled Call Lights: Accessibility and Timely Response Date implemented 10/13/22 states; Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light to each residents' bedside, toilet, and bathing facility to allow residents to call for assistance . Policy Explanation and Compliance Guidelines: 1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. 5. Staff will ensure the call light is within reach of resident and secured, as needed.

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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 - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on interview and record review the facility failed to ensure the resident's right to formulate advance directives for 1 (Resident #356) of 20 residents reviewed for advance directives. The facility failed to ensure that Resident #356s code status was entered in the records at the facility. This deficient practice could place the residents at risk of not having their end of life wishes honored, such as receiving unwanted resuscitative measures. Findings included: Record review of Resident #356's electronic face sheet dated [DATE] reflected he was admitted to the facility on [DATE] and original admitted [DATE]. His diagnoses included Nontraumatic Acute Subdural Hemorrhage (buildup of blood on the surface of the brain), Type 2 Diabetes Mellitus without Complications, Hemiplegia (one sided muscle paralysis or weakness), Essential Primary Hypertension (high blood pressure). Record review of Resident #356's Brief Interview of Mental Status Form had a BIMS score of 10, indicating Resident #356 cognition was moderately impaired. Record review of Resident #356's physician order summary report, dated [DATE], did not have an active physician's order for code status: Full Code Status or any other order to support her advanced directive. During an interview on [DATE] at 3:30pm with LVN A, stated she could not find the code status on the resident's electronic chart. She stated the admission nurse was responsible for entering the code status. She was not sure if that was her because they take turns doing admissions. She stated she does not have any code status to go by so she would have to say the resident was a full code. She stated at any time if they do not know or does not have the out of hospital paperwork for the DNR they keep them as full code. LVN A stated the negative outcome would be that she brought a resident back to life that was a DNR or vis versa, not code someone that was not DNR. During an interview on [DATE] at 3:40pm the DON, stated if they do not have the DNR paperwork on hand, they do not look at the facilities electronic record system because it could be wrong. He stated that a resident would be considered a Full code if there was no code status or if they do not have the DNR paperwork. The DON stated that the negative outcome would be if the resident was unresponsive and if there was no paperwork, they have to do CPR and the consequences were that the family did not want CPR, no pursuing extra measures. He stated that they have to educate residents to sign DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:25 AM the Social Services , stated she discusses advance directives during admission. She then documents this information and discusses it in the care plan meeting. She stated she thought she had 5 days to complete the advance directives. She normally does it right away. The resident will be considered full code until she gets this information. She will then let the nurse know immediately that resident was DNR, and she was pending doctors' signature on advance directive form. During an interview on [DATE] at 03:10pm with LVN H, stated she was the admission nurse. She stated that if she does not get an ooh DNR right away then she puts the resident as a full code. She stated that maybe she forgot to enter the code status. LVN H stated the negative outcome would be not knowing if the resident was a full code or DNR. Record review of the facility's policy subject titled, Residents Rights Regarding Treatment and Advance Directives, Implemented [DATE], revealed Policy Statement It is the policy of this facility to support and facilitate a resident right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Policy Explanation and Compliance Guidelines 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on interviews and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission that included the instructions needed to provide effective and person-centered care of 1 (Resident #356) of 4 residents reviewed for baseline care plan completion. The facility failed to complete the advance directive section in the baseline care plan for Resident #356 within the required 48-hour timeframe. This deficient practice could place the residents at risk of not having their end of life wishes honored, such as receiving unwanted resuscitative measures. Findings included: Record review of Resident #356's electronic face sheet dated 06/24/24 reflected he was admitted to the facility on [DATE] and original admitted [DATE]. No advance directive information on this form. His diagnoses included Nontraumatic Acute Subdural Hemorrhage (buildup of blood on the surface of the brain), Type 2 Diabetes Mellitus without Complications, Hemiplegia (one sided muscle paralysis or weakness), Essential Primary Hypertension (high blood pressure). Record review of Resident #356's had a BIMS score of 10, indicating Resident #356 cognition was moderately impaired. Record review of Resident #356's baseline care plan revealed the Advance Directive section was not completed. Record review of Resident #356's physician order summary report, dated 06/24/24, did not have an active physician's order for code status: Full Code Status or any other order to support her advanced directive. During an interview on 6/24/24 at 3:30pm LVN A, stated she could not find the code status on the resident's electronic chart. She stated the admission nurse was responsible for entering the code status. She was not sure if that was her because they take turns doing admissions. She stated she doesn't have any code status to go by so she would have to say the resident was a full code. She stated that at any time if they don't know or don't have the out of hospital paperwork for the DNR they keep them as full code. LVN A stated the negative outcome would be that she can bring a resident back to life that was a DNR or vis versa, not code someone that was not DNR. During an interview on 6/27/24 at 10:17 AM the MDS, stated the nurses open the initial baseline care plan. Then he completed the comprehensive care plan. He stated he has 14 days to complete the comprehensive care plan. He stated the social services are the one who take care of completing the code status. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 at 10:25 AM the Social Services, stated she discusses advance directives during admission. She then documents this information and discusses it in the care plan meeting. She stated she thought she had, 5 days to complete the advance directives. She normally does it right away. The resident will be considered full code until she gets this information. She will then let the nurse know immediately that resident was DNR, and she was pending doctors' signature on advance directive form. Record Review of the facility policy subject titled, Baseline Care Plan revised October 05, 2023, revealed policy statement The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 4 residents (Resident #63) reviewed for care plans, in that: The facility failed to ensure Resident #63's comprehensive care plan dated 05/29/2024 reflected she was in the secured unit due to a high risk of elopement. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and no having personalized plans developed to address their specific needs. The Findings included: Record review of Resident #63's face sheet dated 06/11/2024 reflected an [AGE] year-old female with an admitted [DATE]. Resident #63's relevant diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of Resident #63's quarterly MDS assessment dated [DATE] reflected a BIMS score 99, which indicated Resident #63's cognition was severely impaired. Section E reflected no behavior symptoms. Record review of Resident #63's quarterly Care Plan assessment dated [DATE] reflected resident had an elopement/wanderer risk related to impaired safety awareness, dementia. Date initiated/revised 02/23/2024. Interventions included complete wandering evaluation tool, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. resident prefers activities such as watching television and loteria. Date Initiated/revised: 02/23/2024 Record review of Resident #63's orders reflected an order dated 04/24/2024 reflected to be admitted to secured unit due to a high risk of elopement. An observation on 06/24/2024 at 9:30 a.m., Resident #63 was observed in the dining room of the facility's secured unit. She was sitting in her wheelchair, and she was dressed in her own personal clothing. Resident #63 was well groomed and was participating in the morning activities (coloring). An attempted interview on 06/24/2024 at 9:35 a.m. Resident #63 was not interviewable. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/24/2024 at 9:35 a.m., the MDS-LVN said Resident #63 had been admitted to the facility's secured unit on 04/24/2024. She said her care plan should have reflected she was housed in the secured unit. The MDS-LVN said she completed Resident #63's care plan but must have forgotten to indicate she was housed in the facility's secured unit. The MDS-LVN said there were no negative outcome to Resident #63 not having her car plan indicate she was house in the facility's secured unit. An interview on 06/26/2024 at 2:00 p.m., The DON said Resident #63's care plan should have indicated she was housed in the facility's secured unit. He said there were no negative outcomes to Resident #63 for not having her care plan include she was housed in the facility's secured unit. Record review of facility's Comprehensive Care Plans policy dated 10/24/22 reflected: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in a resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the president's personal and cultural preferences in developing goals of care Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761 Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible for 1 of 2 residents (Resident #255) reviewed for indwelling catheters. The facility failed to prevent Resident #255's urinary catheter tubing from touching the floor. This failure could place residents at risk for urinary tract infections. Findings included: Record review of Resident #255's admission record dated 06/25/24 reflected Resident #255 was admitted to the facility on [DATE]. Resident #255 was an [AGE] year-old male with diagnosis which included benign prostatic hyperplasia without lower urinary tract symptoms (an age-associated prostate gland enlargement that can cause urination difficulty), and acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood. Acute kidney failure develops rapidly over a few hours or days and can be fatal.) Record review of the quarterly MDS dated [DATE] reflected Resident #255 was severe cognitive impairment (never/rarely made decisions) and had an indwelling catheter in place. Record review of Resident #255's the physician orders dated 06/25/24, reflected orders for a foley catheter to be changed as needed, start date 06/10/24. Record review of Resident #255's care plan revealed on 06/07/24 reflected Resident #255 had an indwelling urinary catheter. Interventions included to position catheter bag and tubing below the level of the bladder and away from the entrance of door. Observation on 06/24/24 at 11:02 am revealed Resident #255 was in his bed, alert and wearing a urinary catheter was clipped to the bedside rail below his bladder level. The tubing did not have a plastic sleeve and was on the floor and attached to the urinary catheter. In an interview on 06/25/24 at 01:40 pm LVN A stated the floor nurse for the day was the one responsible for the Foley catheters. LVN A stated the catheter tubing should not be on the floor. LVN A stated, maybe we should put the sheath on the catheter tubing so even if the tubing touched the floor, there would not be an infection control issue. In an interview on 06/26/24 at 05:32 PM the DON stated they were now going to place sheaths on the catheter tubing of residents with catheters. The DON stated they already do that for oxygen. The DON stated if a catheter tubing was on the ground, it was an infection control issue and it should never be on the ground. The DON stated in-services were ongoing at the facility for catheters. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/27/24 at 1:00 pm the Administrator was asked for policy on catheter care or infection control. The policies were not provided prior to exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided with professional standards of practice for 2 of 4 residents (Resident #258 and Resident #260) reviewed for oxygen in that: 1.Resident #258's oxygen was administered at 3.5 Lpm instead of 2 Lpm via nasal cannula as ordered by physician. 2.Resident #260's oxygen was administered at 2.5 Lpm instead of 3.0 Lpm via nasal cannula as ordered by physician. This failure could place residents who receive respiratory care at risk of developing respiratory complications and a decreased qualify of care. The findings included: 1.Record review of Resident #258's Admission Record dated 06/25/24, revealed an [AGE] year-old female, admitted to facility on 06/14/24. Her diagnosis included: Acute respiratory failure (a sudden inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide from tissues), chronic pulmonary edema (a long-term condition that occurs when fluid builds up in the lungs), pneumonia (an infection that inflames air sacs in one or both lungs which may fill with fluid), acute systolic (congestive) heart failure (a type of heart failure that occurs when the left ventricle of the heart cannot contract normally which prevents the heart from pumping enough blood with enough force to circulate throughout the body). Record review of Resident #258's admission MDS dated [DATE] revealed a BIMS score of 06, indicating moderately impaired cognition. MDS Section O Special Treatments, Procedures, and Programs Respiratory Treatments was not completed. Record review of Resident #258's Care Plan dated 06/21/24, revealed, FOCUS: o The resident has oxygen therapy r/t Respiratory illness, Acute Respiratory Failure, Pneumonia, Lung Disorder. Date Initiated: 06/24/2024 Revision on: 06/24/2024. INTERVENTIONS/TASKS: o If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula). Return resident to usual oxygen delivery method after the meal. Date Initiated: 06/24/2024 CNA LN RN o Provide reassurance and allay anxiety: Have an agreed-on method for the resident to call for assistance (e.g., call light, bell). Stay with the resident during episodes of respiratory distress. Date Initiated: 06/24/2024 CNA LN RN. Record review of Resident #258's Order Summary dated 06/18/24 revealed: -Start date: 06/18/24 Discontinued: 06/25/24 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2 liters of oxygen as needed as needed for hypoxia. Record review of Resident #258's Order Summary dated 06/25/24 revealed: Start date: 06/25/24 O2 at 2 LPM every shift related to Chronic Pulmonary Edema; Acute Systolic (Congestive) Heart Failure. Observation on 06/24/24 at 09:48 am Resident #258's door with Oxygen In Use signage on door. Resident #258's oxygen machine was set on 3.5 Lpm. Interview and observation on 06/24/24 at 09:52 am the stated he was going around checking O2 machines. The DON went into Resident #258's room to check Resident #258's O2 machine. The DON stated the machine was set on 3.5 Lpm and was supposed to be set at 2 Lpm. The DON reset the O2 machine to 2 Lpm. The DON stated the nurses are trained on setting the ball meter to the middle of the ball. The DON stated nurses are to check the O2 machine at the beginning of their shift and throughout their shift. 2. Record review of Resident #260's Admission Record dated 06/25/24, revealed a [AGE] year-old female, admitted to facility on 06/14/24. Her diagnosis included: Metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood, which can be brought on by an illness or organ dysfunction), acute respiratory failure (a sudden inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide from tissues) with hypoxia (low levels of oxygen in the tissues), chronic pulmonary edema (a long-term condition that occurs when fluid builds up in the lungs), acute systolic (congestive) heart failure (a type of heart failure that occurs when the left ventricle of the heart cannot contract normally which prevents the heart from pumping enough blood with enough force to circulate throughout the body). Record review of Resident #260's Medicare 5-Day MDS dated [DATE] revealed a BIMS score of 15, indicating no impaired cognition. MDS Section O Special Treatments, Procedures, and Programs Respiratory Treatments revealed continuous oxygen therapy. Record review of Resident #260's Care Plan dated 06/18/24, revealed, FOCUS: o The resident has oxygen therapy r/t CHF, Acute Respiratory Failure, Chronic Pulmonary Edema Date Initiated: 06/18/2024 Revision on: 06/25/2024. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS/TASKS: o Change residents position every 2 hours to facilitate lung secretion movement and drainage Date Initiated: 06/18/2024 CNA o Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. Date Initiated: 06/18/2024 LN RN o OXYGEN SETTINGS: O2 via nasal Date Initiated: 06/18/2024 Revision on: 06/25/2024 CNA LN RN o Position resident to facilitate ventilation/perfusion matching: Use upright, high Fowlers position whenever possible to allow for optimal diaphragm, when on side, the good side should be down (e.g., damaged lung should be up). Date Initiated: 06/18/2024 CNA LN RN o Provide reassurance and allay anxiety: Have an agreed-on method for the resident to call for assistance (e.g., call light, bell). Stay with the resident during episodes of respiratory distress. Date Initiated: 06/18/2024 CNA LN RN. Record review of Resident #258's Order Summary dated 06/18/24 revealed: -Start date: 06/18/24 Discontinued: 06/25/24 2 liters of oxygen as needed as needed for hypoxia. Record review of Resident #258's Order Summary dated 06/25/24 revealed: Start date: 06/25/24 Oxygen at 3 LPM via (specify) every shift for hypoxia. Observation on 06/24/24 at 10:07 am Resident #260's room with Oxygen In Use signage on door. The residents O2 was set at 2.5 Lpm. Ball meter set to top of ball instead of middle. In an interview on 06/25/24 at 01:40 pm, LVN A stated the nurse was responsible for setting the liters per minute on the oxygen machines. LVN A stated the middle of the ball needed to be level with the number and the nurse would have to look at the meter on eye level. LVN A stated oxygen machine was checked when the nurse comes on shift and throughout the day. LVN A stated they had training on the ball meter on the oxygen machine and was very sure they would be getting more training after this survey. In an interview on 06/26/24 at 05:32 pm, DON stated every shift the nurses was to check the oxygen machine with the order to make sure the resident was getting the liters per minute the doctor ordered. DON stated the nurse had to get down to the level of the ball meter to check the setting. DON stated the middle of the ball was to be where the order was set. Review of facility's Medication Administration policy dated 10/24/22 revealed: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Review MAR to identify medication to be administered.

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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** 26141 47828 Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure accurate acquiring and administering of all drugs to meet the need of the resident for four residents (Resident #12, Resident #23, Resident #35, Resident #63) of ten residents reviewed for medications. 1. Resident #12 had four unidentified pills and two capsules in a medication cup on his overbed table that Resident #12 had not taken. 2. The Medication Aide left Resident #12's medications on his bedside table and documented that the medications had been administered. 3. Resident #23 had five medications that were not signed off on the MAR on 06/16/2024 and 06/24/2024. 4. Resident #35 had two medications that were not signed off on the MAR on 06/16/2024 and 06/24/2024. 5. Resident #63 had three medication that were not signed off on the MAR on 06/16/2024 and 06/24/2024. This failure could place residents at risk of not receiving their medications as ordered by their physician. 1. Record review of Resident #12's Admission Record dated 06/26/24 revealed Resident #12 was an [AGE] year old male admitted to facility on 06/23/23 with diagnoses of dementia (progressive or persistent loss of intellectual functioning), type two diabetes mellitus with diabetic polyneuropathy (disease that occurs when blood sugar is too high and damages the nerves in the legs and feet), hyperlipidemia (an abnormally high concentration of fat in the blood), essential (primary) hypertension (when the pressure in your blood vessels is too high), and age-related osteoporosis without current pathological fracture. Record review of Resident #12's quarterly MDS dated [DATE] revealed Resident #12 was able to be understood by others, able to understand others, has moderate cognitive impairment, rarely or never experiences pain, and receives anticoagulant medication. Record review of Resident #12's care plan dated 06/06/23 revealed Resident #12 had hypertension, and the intervention is to give the metoprolol as ordered. Resident #12 had chronic pain r/t diabetic neuropathy and chronic back pain. The intervention was to administer medications for pain as ordered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's Physician's Orders for June 2024 revealed orders for the following medications: Metoprolol tartrate oral tablet 50 mg, give 1 tablet by mouth one time a day for HTN hold if SBP<110 or DBP<60 with a start date of 12/8/2023 and a revision date of 2/23/2024. Namenda oral tablet 5 mg (Memantine HCl), give 1 tablet by mouth one time a day for dementia with start date of 02/10/2024. Gabapentin oral Capsule 100 mg (Gabapentin), give 2 capsules by mouth two times a day for nerve pain with a start date of 4/24/2024. Tylenol extra strength oral tablet, 500 mg (Acetaminophen), give 1 tablet by mouth every 12 hours for pain, a start date of 12/9/2023 and a revision dated of 2/21/2023. Record review of Resident #12's e-MAR for June 2024 revealed: Metoprolol tartrate oral tablet 50 mg was administered on 06/24/24 at 8:00 am Namenda oral tablet 5 mg was administered on 06/24/24 at 8:00 am, Gabapentin oral Capsule 100 mg was administered on 06/24/24 at 8:00 am, Tylenol extra strength oral tablet, 500 mg was administered on 06/24/24 at 8:00 AM. In an interview on 06/24/24 at 10:20 AM Resident #12 said he was hurt and upset and did not want to eat or take his medications because his stomach was upset. Resident #12 said he did not have pain. Resident #12 was upset because the staff had thrown the food his family had brought for him a few days ago. In an interview on 06/24/24 at 11:27 AM ADON/LVN C said the medications were not supposed to be left in the resident's room. ADON/LVN C said the Med Aide was passing out the medications and must have left them on the bedside table. ADON/LVN C said she did not know what the medications were and would check the Resident 12's MAR. ADON/ LVN C took the medications with her. In an interview on 06/24/24 at 11:29 AM Med Aide D said she should have stayed with the resident until he took the meds. Med Aide D said Resident #12 always took them. Med Aide D said that someone had called her, so she just gave him the medications and did not return to make sure Resident #12 had taken them. The Med Aide D said the medications in the cup were Tylenol 500 1 tablet, Eliquis one tablet, Metoprolol one tablet, gabapentin 2 capsules, and Namenda one tablet. Med Aide D said she did not know why resident did not take them. Med Aide D said they do not have residents that wander in this hall or residents that go into other residents' rooms so there was no negative outcome. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/24/24 at 1:44 PM, Med Aide D said the normal procedure for medication administration was she gave the medication to the resident and stayed with the resident until they took the medication. Med Aide D said she takes the blood pressure before administering the high blood pressure medication. Med Aide D said she would give the cup of meds to the resident if they could hold it and if they were not able, she would assist them. Med Aide said she would document as soon as she popped the medication, so she would not forget what she had popped. They have a list in the computer, and she would put a check mark on the medication to indicate that she had taken the medication out of the blister pack. Med Aide D said she documented after the resident was given the medication that the resident took the medication. Med Aide D said Resident #12 always took them. In an interview on 06/24/24 at 01:56 PM the DON the med aide should have waited until the resident took the medications or if he refused, she should have taken them and then returned and asked if resident wanted to take them. The Med Aide should not have left them in the resident's room. ADON/LVN C went in and did a head-to-toe assessment and asked Resident #12 if he would take the medications and Resident #12 refused to take the medications. The DON said they would correct the documentation that the Med Aide did, and they would document that the patient refused. The DON said Resident #12's PCP was informed of resident refusing the medications. The DON stated the doctor said they should take the vital signs and if they are fine then it's ok to miss one dose. In an interview on 06/24/24 at 2:40 PM Med Aide E had been employed five years. The process to administer medications would be he started with the blood pressure reading and then the med pass. When he popped the medication, he took one pill and signed that he popped the medication, then he would pop each one and sign for each medication that was popped from the blister pack. Then he would close the computer and would take the medication to the resident. Med Aide E said they had to stay with the resident until he took the last pill. Once the resident had taken the medication he would go back to the computer and sign that the resident had taken the medication. If the resident refused, he would tell the nurse and then would try two more times to administer it. If the resident refused again them, he would sign that the resident refused. Once he had offered it three times there is not much he can do, and the nurse would decide what she needed to do. In an interview on 06/26/24 at 9:29 AM NP F said the Med Aide should know better than to leave the medications with the resident. The Med Aide should have stayed until Resident #12 took his medications. In an interview on 06/27/24 at 12:12 PM NP G said if a resident did not receive his pain medication he would not do well, would not participate in rehab, and would not improve his quality of life. If a resident did not take the pain medication as scheduled it would not be as effective. If a resident missed a dose of the high blood pressure medication, a one time dose would not be a concern, the resident would have a change in his blood pressure. 2.Record review of Resident #23's face sheet dated 06/25/2024 reflected an [AGE] year-old female with an admitted [DATE] and an initial admitted [DATE]. Resident #23's relevant diagnoses included dementia (loss of memory, language, problem-solving and other thinking ability's that interfere with daily life), Parkinson's (a disorder of the central nervous system that affects movement, often including tremors), edema (swelling), muscle wasting and atrophy (wasting or thinning of muscle mass), and acute chronic combined systolic and diastolic heart failure (congestive heart failure.) (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 #23's annual MDS assessment reflected a BIMS score of 8 which indicated she had moderately impaired cognition. Record review of Resident #23's annual care plan reflected: Problem: The resident has coronary artery disease (CAD) r/t atherosclerosis. Date Initiated: 03/14/2023. Interventions: Encourage compliance to treatment regimen and follow up with physician, give meds for hypertension and document response to medication and any side effects, give meds to control cholesterol level as ordered by the physician, date initiated 03/14/2023. Problem: The resident has GERD, date Initiated: 01/16/2023 Interventions: Give medications as ordered, date initiated: 01/16/2023 Problem: The resident has Parkinson's, date initiated 11/23/2022. Interventions: Give medications as ordered by the physician, date initiated: 11/23/2022. Problem: The resident has (chronic) pain r/t diabetic neuropathy, date initiated: 12/06/2022. Interventions: Administer medication as per orders, date initiated: 12/06/2022 Record review of Resident # 23's physician orders on 06/25/2024 reflected: Baclofen oral tablet 10 mg, give 1 tablet by mouth two times a day related to Parkinson's disease with dyskinesia date started 06/13/2024. Sacubitril-Valsartan Oral Tablet 24-26 MG (Sacubitril-Valsartan). Give 1 tablet by mouth every 12 hours for HTN DO NOT ADMINISTER IF BP <110/60. Date started 06/11/2024. CARBIDOPA-LEVODOPA 25-100 TAB. Give 1 tablet by mouth four times a day for PARKINSONS. Date initiated 06/05/2024. PREDNISOLONE AC 1% eye drop. Instill 1 drop in left eye four times a day for eye condition, date started 05/19/2024. Pramipexole Dihydrochloride Oral Tablet 0.5 MG (Pramipexole Dihydrochloride). Give 1 tablet by mouth two times a day related to Parkinson's Disease with dyskinesia. Date started: 04/14/2024 Record review of Resident #23's June 2024 MAR reflected the following medications were not signed off on 06/16/2024 and 06/24/2024 at 4:00 p.m.: Baclofen Oral Tablet 10 mg, Sacubitril-Valsartan Oral Tablet 24-26 mg, Prednisolone AC 1 %, Carbidopa-Levodopa oral tablet 25-100 mg, and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pramipexole Dihydrochloride oral tablet 0.5 mg. 3.Record review of Resident #35's face sheet dated 06/24/2024 reflected an [AGE] year-old female with an admitted [DATE] and an initial admitted [DATE]. Resident #35's relevant diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anemia (a condition in which the blood does not have enough healthy red blood cells and hemoglobin), and hypertension (a condition in which the force of the blood against the artery walls is too high.) Record review of Resident #35's quarterly MDS assessment dated [DATE] reflected a BIMS score of 3 which indicated she had severe cognition impairment. Record review of Resident #35's quarterly care plan reflected a: Problem: The resident has hypertension (HTN), date initiated: 05/19/22. Interventions: Give anti-hypertensive medications as ordered, date Initiated: 05/19/22. Problem: The resident has anemia, date initiated: 05/19/22. Interventions: Give medications as ordered. Monitor for side effects, effectiveness, date initiated: 05/19/22. Record review of Resident #35's physician orders on 06/25/2024 reflected: Folic Acid Oral Tablet 1 mg (Folic Acid). Give 1 tablet by mouth two times a day for supplement. Start date 06/27/24. Metoprolol Tartrate Tablet 25 MG. Give 1 tablet by mouth two times a day for HTN. Start date 07/14/23. Record review of Resident #35's June 2024 MAR reflected the following medications were not signed off on 06/16/2024 and 06/24/2024 at 4:00 p.m.: Folic Acid Oral Tablet 1 mg Metoprolol Tartrate Tablet 25 MG 4. Record review of Resident #63's face sheet dated 06/11/2024 reflected an [AGE] year-old female with an admitted [DATE]. Resident #63's relevant diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) ,hyperlipidemia (high levels of fat particles (lipids) in the blood), bilateral hearing loss (hearing loss that affects both ears), acute kidney failure (a condition in which kidneys suddenly can't filter waste from the blood), heart failure (a condition in which the heart does not pump blood as well as it should), and hypertension (a condition in which the force of the blood against the artery walls is tool high). Record review of Resident #63's quarterly MDS assessment dated [DATE] reflected a BIMS score 99, which indicated Resident #63's cognition was severely impaired. (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 #63's quarterly care plan reflected the following: Problem: The resident is on anticoagulant therapy Eliquis r/t DVT, date initiated: 10/02/23. Interventions: Administer Anticoagulant medications as ordered by physician, ELIQUIS. Problem: The resident is on diuretic therapy r/t edema, date initiated 01/29/24. Interventions: Administer Diuretic medications as ordered by physician, LASIX (furosemide), date initiated 01/29/24. Problem: The resident has GERD r/t hyperacidity, date initiated: 01/29/24. Interventions: Give medications as ordered. Monitor/document side effects and effectiveness, date Initiated: 01/29/24. Record review of Resident #63's physician orders on 06/25/2024 reflected: Eliquis Oral Tablet 2.5 MG (Apixaban), give 1 tablet by mouth two times a day for DVT to upper extremities, date dispensed: 06/05/24. FUROSEMIDE 20 MG TABLET, give 1 tablet by mouth two times a day for Edema, date dispensed: 06/08/24. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG (Pantoprazole Sodium), give 1 tablet by mouth two times a day for GASTRIC ULCER, date dispensed 06/11/24. Record review of Resident #63's June 2024 MAR reflected the following medications were not signed off on 06/16/2024 and 06/24/2024 at 4:00 p.m.; Eliquis Oral Tablet 2.5 MG (Apixaban), FUROSEMIDE 20 MG TABLET, Pantoprazole Sodium Oral Tablet Delayed Release 40 In an interview on 06/27/24 at 9:40 a.m., RN J said she covered hall 400 from 2:00 p.m. to 6:00 p.m. on 06/24/2024. She said before she administered any medication(s), she made sure it's the right resident, right time, right drug, right dosage, and right route. She said she remembered giving Resident #23, Resident #35, and Resident #63 their medications at 4:00 p.m. She said she was going through personal issues and must have forgotten to sign them off on their MAR. RN J was not able to say if there were any negative outcomes to Resident #23, Resident #35, and Resident #63 for not signing off their medication on their MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 06/27/24 at 2:37 p.m., Med-Aide K said she administered medications to residents in hall 400 on 06/16/2024 at 4:00 p.m. She said she did administer Resident #23, Resident #35, and Resident #63 their medications at 4:00 p.m. Med-Aide K said that day was Father's Day and felt overwhelmed with the number of visitors on the floor and must have forgotten to sign off their medication of the MAR. She said possible negative outcome to Resident #23, Resident #35, and Resident #63 could run the risk of receiving a double dose since it was not signed out on the MAR. An interview on 06/27/2024 at 2:45 p.m., the DON said if the nursing staff/med-aide failed to sign off a medication, resident's run the risk of receiving a double dose. The DON said every morning he and the rest of the IDT members reviewed all reports from the previous day that appeared in red on PCC's dashboard. He said if a report appeared in red it meant there was a signature missing. He said one of the reports they reviewed daily was the MAR. The DON said if he discovered a nursing staff/med-aide failed to sign off a medication, the first thing he would do was to have a meeting with them to make sure the medications were administered. The DON said it was his responsibility to make sure nursing staff/med-aides signed off all medications. He said he must have missed the 06/16/2024 and 06/24/2024 reports. Record review of facility's policy on Medication Administration dated 10/24/22 revealed: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 10. Review MAR to identify medication to be administered. 13. Remove medication from source, taking care not to touch medication with bare hand. 14. Administer medication as ordered in accordance with manufacturer specifications. 15. Observe resident consumption of medication. 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. Record review of facility's Job Description of Certified Medication Aide indicated the Certified Medication Aide will prepare, administer, and document prescribed medications per protocol. Essential Functions Administer prescribed medications and treatments as defined by state regulations in accordance with company policy and procedure. Take and record vital signs prior to administration of medication which could affect or change the vital signs. Reports to charge nurse and documents reasons prescribed drugs are not administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Be able to accurately follow all principals of good medication administration.