STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676204	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 5 residents (CR #1) reviewed for quality care. The facility failed to ensure CR #1 did not receive Hydrocodone-Acetaminophen (Norco) after it was discontinued after her hospital visit on [DATE] but was not discontinued in her chart. CR #1 received Norco more frequently than the order that remained in her chart on [DATE]. She experienced lethargy, nausea, vomiting, and decreased response to stimuli and expired at the hospital later that evening. An Immediate Jeopardy was identified on [DATE] at 4:33 p.m. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place the resident at risk for not receiving medications as ordered resulting in serious injury, decline in health, and death. Findings included: Record review of CR #1's admission record dated [DATE] revealed a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included hypotension (low blood pressure), muscle weakness, type 2 diabetes, end stage renal disease, dependence on renal dialysis, other abnormalities of gait and mobility, need for assistance with personal care, and chronic embolism and thrombosis of other specified veins (conditions involving persistent blood clots that can obstruct blood flow). Record review of CR #1's Discharge MDS assessment-return anticipated dated [DATE] revealed her cognitive skills for daily decision making were moderately impaired. She required assistance from staff with ADL care. Record review of CR #1's care plan dated [DATE] revealed the resident was full code (providing chest compressions in the event of cardia arrest). Interventions were to monitor for decrease in change of condition and report to the MD and responsible party. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's Nursing note dated [DATE] written by LVN G read in part, During morning assessment resident noted to be lethargic and not answering nurse when asking question resident eyes PERRLA aroused to touch . BP 130/86 P 87 MD made aware new orders received for stat labs CBC/BMP labs were collected. Resident went to dialysis BP was low Midodrine was given BP went up to 108/67 then started dropping again . (family) came to visit resident stated resident looks worse then [sic] yesterday and wanted her sent to ER MD made aware of family request and called for preferred to pickup . Record review of CR #1's hospital record dated [DATE] -[DATE] read in part, .chief complaint: weakness - generalized pt from (facility) and report pt has been getting weaker for several days .ED course . [DATE] at 11:32 p.m. Pt more alert on re eval, counseled on findings. Suspect that her symptoms may be due to Norco. Counseled on cessation of Norco for the next few days . Final Diagnoses: generalized weakness . Medication changes: Hydrocodone/acetaminophen 10-325 mg 1 tablet every 6 hours prn (there was a line struck through it). Record review of CR #1's nursing note dated [DATE] written by LVN N read in part, .resident return from hospital this morning aprx, 0530 (5:30 a.m.), via ambulance . resident stable, no c/o pain or discomfort noted at time of arrival . discharge instructions include DC of Norco 10-325 no other changes to medications made . Record review of CR #1's Order Summary Report dated [DATE] revealed an order for Hydrocodone-Acetaminophen (Norco) 10-325 mg 1 tablet by mouth every 6 hours as needed for pain, order date [DATE], discontinued [DATE]. Record review of CR #1's Medication Administration Record for [DATE] revealed Hydrocodone-Acetaminophen 10-325 mg 1 tablet every 6 hours as needed for pain was documented as administered on [DATE] at 8:10 a.m. There was no other administration documented on [DATE] for Hydrocodone-Acetaminophen. Record review of CR #1's Controlled Drug Administration Record for Hydrocodone-Acetaminophen (Norco) 10-325 mg dated [DATE] revealed one tablet was documented as administered to CR #1 on 4/4/(24) at 6 a. m. by LVN D and another tablet was documented as administered 2 hours later on 4/4/(24) at 8 a.m. by LVN J. Record review of CR #1's nursing note dated [DATE] at 12:38 p.m. written by LVN J read in part, 'Resident is drowsy; Norco's overdose noted. Resident has refused meals: breakfast and lunch. Monitoring in progress. Record review of CR #1's nursing note dated [DATE] at 12:56 p.m. written by the previous DON read in part, DON was called to resident's room due to resident being drowsy after returning from dialysis around on assessment resident was arousable and verbally responsive stating she was tired and wants to sleep. Charge Nurse stated resident was given PRN Norco before going to dialysis. Record review indicated resident was given an extra dose of Norco 2 hours after the previous dose instead of every 6 hours. MD made aware. MD instructed to monitor resident for responsiveness. Record review of a text message conversation provided by the facility with MD R dated [DATE] at 12:56 p.m. read, Also (CR #1) can [sic] given Norco sooner 2 hours apart instead of 6 hrs because night did not document in emar that she gave a dose a 6 pm [sic]. Morning nurse gave it again when resident asked for pain meds. She is talking but more sleepy . MD R responded, Yes she can have the early dose. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's nursing note dated [DATE] at 3:06 p.m. written by LVN J read in part, Resident has nausea and vomiting. Change of condition. Has called physician for new order. Message left via voicemail. Record review of CR #1's vital signs on [DATE] at 3:36 p.m. revealed her blood pressure was 80/57 mmHg. Her respirations were 16 breaths/minute and oxygen was 96% on [DATE] at 2:11 p.m. Record review of CR #1's nursing note dated [DATE] at 6:19 p.m. written by LVN D read Patient administer oxygen per nasal canula at 3L. The EMS received vital signs and decided to transport patient for acute care . Record review of CR #1's nursing note dated [DATE] at 8:18 p.m. written by LVN D read, Upon attempting to administer patient scheduled medication, patient appears to have increased lethargy. O2 level obtained at 90% on RA upon assessment. Patient sternal rubbed and minimally responsive to stimuli. EMS Service contacted for acute care transport to ED. Pt assessed via 6 EMS transport to (hospital). Record review of CR #1's hospital records dated [DATE] read in part, .Patient presents with cardiac arrest . EMS reports (facility) staff stated pt was in respiratory distress all day and progressively getting worse. Per EMS pt was having agonal breaths upon arrival to scene and pt went inyo [sic] cardiac arrest on ambulance. Patient downtime wa [sic] 1 minute before arrival to ED, no meds given en route Medical Decision Making . EMS reports they were called to the patient's nursing home due to severe respiratory distress, on their arrival patient was obtunded, severe respiratory distress, and route to ER patient became apneic and lost pulses and they started CPR. CPR was initiated 2 minutes prior to arrival . after 20 minutes of CPR, decision was made to terminate interventions. Time of death called at 9:09 p.m. In a telephone interview on [DATE] at 10:38 a.m. the previous DON said the night nurse administered Norco to CR #1 prior to leaving her shift and documented it in the narcotic book but did not document it in the eMAR. She said the morning nurse arrived and the resident asked for pain medicine, and he administered the same medication within 2 hours instead of 6 hours. She said the Norco was scheduled for every 6 hours. She said the facility notified MD R and he said it was not a problem and ok to give the medication sooner and to just keep an eye on her. She said she could not recall if CR #1 had an order for the Norco. She said CR #1 was a little sleepy but was herself and they monitored her. She said CR #1 was in and out of the hospital very frequently and did not remember if she went out to the hospital that day. She said she in serviced LVN J who was an agency nurse and did not allow him to come back to the facility. She said staff should document administered narcotics in both the eMAR and narcotic book because there could be a risk of double dosing the resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 10:53 a.m. CR #1's family member said the resident admitted to the facility for rehabilitation. He said hospital staff informed him a few times that CR #1 was overmedicated with pain medication. He said when he visited her at the facility, she was not all the way there, she was in and out, more quiet, exhausted, and not there at all. He said she deteriorated at the facility and was never like that before. He said on [DATE] he went to the facility to check on her and she was particularly out of it that day. Her body was cold, she was responsive but was in and out. He said she vomited on herself around 11:30 a. m. - 12:30 p.m. He reported it and staff arrived but did not ask about the vomiting. He said she went to sleep and later that evening around 10:45 p.m. the facility called another family member to inform her she was at the local hospital and her oxygen was low, but blood pressure was fine. He said when he arrived at the ER he was met with an empty room and a body bag on top of the gurney. In a telephone interview on [DATE] at 11:16 a.m. LVN D said she did not remember a possible overdose and did not remember sending CR #1 to the hospital. In a telephone interview on [DATE] at 11:38 a.m. MD R said CR #1 went to the hospital on 3/22-23/24 due to generalized weakness. He said if the Norco was supposed to be stopped the facility should reconcile with the MD and it should be stopped but said he was not sure if it was discontinued because he did not see the DC in the hospital records. He said the ED recommended to stop CR #1's Norco due to weakness, not from overdosing. He said he was unsure if he was notified of the Norco overdose (on [DATE]). He said the risk of a Norco overdose would depend on the patient and monitoring was important. He said CR #1 had ESRD and should be monitored pretty closely. In a telephone interview on [DATE] at 12:02 p.m. MD G said she did not recall the incident and was not notified of anything regarding CR #1. She said if the Norco order was for every 6 hours she did not know why it was administered in 2 hours. She said Norco could upset the stomach and lethargy could happen if Norco was given too early. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 12:15 p.m. the Regional Nurse said she was unsure of when the facility stopped using nursing agencies. She said she was unsure of anything that happened to CR #1, only what was in the chart. She said the expectation was for nurses to document when giving the medication to the residents and they should follow the order as prescribed. If there was a change in condition the resident should be assessed, and the physician notified and documented. If the physician did not respond, staff should call back and if no response, the medical director is to be called. Depending on the status of the resident, if the resident was in respiratory distress or vital signs too low or high, staff could use nursing judgement for the resident's safety. For medication pass, it is documented on the eMAR and the narcotic count book/log. If doing medication pass, both the eMAR and narcotic book should be reviewed before administering the medication. When residents return from the hospital the discharge summary is reviewed by the nurse who is accepting the resident. The nurse will then input the discharge summary into PCC. They are checking the medications are input correctly into PCC. They are to verify the orders with the attending doctor to ensure they agree for the resident's care. If a resident is given discontinued medication, they did not follow the MD orders and the resident could be at risk. She noticed when the resident came back from the hospital, the nurse wrote D/C Norco, but it was not discontinued. She did not review the discharge hospital summary. She also read that the resident received extra Norco. Per the notes, the resident was lethargic and not as responsive. She did know she had cardiac arrest and passed away. She did not believe the extra Norco caused CR #1's death. She was unsure if the resident was to be on the Norco but noticed that it was discontinued, and did not know why. She did read the resident asked to go to the hospital previously to get Morphine. Record review of the discontinued medications policy, states the nurse documents the order to discontinue the medication in the resident's record. The Physician's order sheet (POS) and the medication administration record (MAR) are updated to indicate that the order is discontinued. Alternatively, the discontinuation order is entered into the facility's EHR system. Record review of the general guidelines for medication administration policy, states always employ the MAR during medication administration. Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. Record review of Change in condition policy, states that once the nurse has notified the physician for a change in condition the resident/patient will be monitored for 1 hour until the physician has responded. The monitoring will include vital signs, pulse ox, and finger stick blood sugar if diabetic (one time only). A physical assessment should be completed relative to the symptoms present and a pain assessment. If resident/patient condition appears emergent transfer to local ER may occur without physician order. On [DATE] at 4:33 p.m. the regional nurse and administrator were informed that an Immediate Jeopardy situation was identified due to the above failures and a Plan of Removal was requested. The following Plan of Removal was submitted by the facility and accepted on [DATE] at 9:47 p.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Inservice & Education Record dated [DATE] - Medication is to be administered as ordered by the MD. Charge nurses are to follow the 5 rights of med administration - right med, right patient, right dosage, right route and right time. Staff not following the above will receive disciplinary action up to and including termination. There were 10 signatures (MA, RN, LVN) Record review of Inservice & Education Record dated [DATE] - Resident noted with a change in condition is to be assessed by the nurse and MD notified - res is to continue to be assessed if unable to reach physician within 2 hours. Repeat call - if you still cannot reach MD call the Medical Director - if resident/pt condition appears emergent send to ER. There were 8 nurse signatures. Record review of Inservice & Education Record dated [DATE] - Medication error - MD is to be notified of any medication error and resident is to be monitored for any adverse reactions. There were 8 nurse signatures. Record review of Inservice & Education Record dated [DATE] - PRN medications are to be documented on narcotic count sheet and on MAR in resident chart after medication administered. Resident to be assessed for pain with shift and document effectiveness of pain medication. There were 8 nurse signatures. Record review of Medication Pass Audits dated [DATE]. There were 5 audits conducted with no errors. Record review of Inservice & Education Record dated [DATE] - Medication Administration, prn documentation, following 6 rights of medication pass, preventing medication errors. Check and balance of admission/discharge medication reconciliation, MD orders - PCC, notification of medication error to MD, med pass audit will be observed 1st day back to work before hitting the floor to pass meds. There were 4 nurse signatures. In an interview on [DATE] at 1:18 p.m. LVN B (Charge nurse 6 a.m. - 6 p.m.) said she was trained to document changes in condition, monitor, and follow up with the MD and Medical Director. If the situation was emergent, she would send them out so the patient is not compromised. The 5 rights of medication administration include to use the right medication, patient, route, time, and document pain on MAR and on narcotic sheet and ensure the times match too because it could be a medication error. She said you document a change in condition in the assessments einteract SBAR, notify the MD right away let them know what is going on, and notify the DON of changes. She said she would keep assessing the patient for any changes either better or worse and document if interventions have helped. She said PRN medications should be reassessed around 15-45 minutes later to ensure efficacy. If there was a medication error, she would notify the DON right away, go through the steps of what happened, do an investigation, notify the MD, assess the resident for adverse reactions, and monitor them very closely for any issues. She would monitor vital signs, alertness, cognition and compare to baseline. For hospital discharge orders she would verify the medications from the hospital with the MD and enter the medication in properly. She said if a medication was discontinued, she would discontinue medication from the system, put in a progress note, and remove medication from the cart. She said she had to do a medication pass with a staff member. She said the MD order would say how often you can administer the medication; she would go in the computer to see when it was last administered and to see if it was too soon or not. She said she also checked the narcotic book just in case it was not documented in the eMAR. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 1:32 p.m. RN B said the 5 rights of medication pass were to ensure the right person, route, dose, medication, and time. She said a medication pass was conducted. For change in condition, she would document and notify the MD, get a timely response and follow up, send the resident out to the hospital if necessary and report to MD and oncoming shift for follow up. She said she could also reach out to the DON and Administrator and follow up with the Medical Director on what needs to get done. If severe enough send out resident to 911. For hospital discharge orders she said she would reconcile the medication and compare what is new and notify MD who does the final reconciliation. For a change in condition she would assess for new pain, assess the vital signs, check alertness/change in cognition, notify findings to MD and follow orders. She would always do a progress note and look for a change in condition form. If there was a medication error, she would complete an incident report, document, and notify superiors, MD, RP, assess the patient for changes, adverse effects, signs and symptoms to watch for, and continue to monitor the resident. When administering prn narcotics, she would document the prn narcotic in PCC and narcotic log because they do not serve the same purpose. She said PCC showed when the medication was given last, and the narcotic log count sheet purpose was to obtain a proper count. In an interview on [DATE] at 1:52 p.m. LVN F (6 a.m. - 6 p.m.) said she was trained on documenting in the MAR and narcotic book when administering a prn medication so that you do not overdose but give the proper dosage. If there was a change in condition, she would notify the MD and if they did not respond within 2 hours she would go to the medical director, if emergent call 911, don't wait. She would document the change in condition under assessments with option for change in condition. She would determine the symptoms, if new or chronic, which body system did it pertain to, most recent vitals, and situation. She would monitor the resident and implement intervention. If the intervention did not work, she would notify the doctor again. For discharge hospital orders she said if a medication was not on the discharge list you could not give it and could not just go back to what they had prior to the hospital. She said she would reconcile the orders with the MD. She said the 5 rights of medication administration were - right patient, right dosage, right form, route, and time. She said every medication should have the right time if not, question the doctor. She said for a medication error she was trained to alert whoever was in charge, start monitoring for side effects such as respiratory depression, and notify the MD. She said she would monitor the resident for at least 24 hours depending on the drug. In an interview on [DATE] at 2:13 p.m. MA J (2 p.m. - 10 p.m.) said the 5 rights of medication administration were the right patient, medication, dose, time, and route. She said she was trained to follow MD orders. She said if the resident asked for pain medication that was already given, she would notify the nurse that it was already given. She said narcotic medication should be documented on the narcotic book and on the computer. In an interview on [DATE] at 7:46 p.m. LVN E said she had recent in services on medication administration, 5 rights of medication, identifying the patients, when to send residents out, and many others. When administering medications, she would first look up the patient and go over the eMAR, verify the order is correct, and current, then she would locate the medication and ensure the order is what she is supposed to give. She would do hand hygiene, identify pt by photo and by confirming with pt. then she would verify medication at bedside, check expiration date, look over eMAR, make sure it's the right medication, then administer medication. She would document the medication on the eMAR. As soon as she realized she gave the wrong medication, she would contact provider, get baseline set of vitals and monitor condition and mental status and continue to monitor for any change in condition. She would contact 911 if change in condition or if doctor orders her to send pt out. (continued on next page)

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	676204	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 7:55 p.m. LVN C said she had in services on medication administration, when to contact Physician, RP, POA, change in condition in services. They were given yesterday. She said she knows the 5 rights, patient, drug, dose, routes, time, follow up effectiveness, allergies, when to notify MD and antibiotics and safety concerns. She would first identify pt, double check drug, drug label against eMAR, correct dose, correct route, and time, monitor for any adverse effects. She said that she would monitor vital signs, if suspected over dose, notify physician, DON, RP , and if critical or obstruction of airway, loss of conscious, then move to code status, notify hospice if necessary, make determination if sent out for evaluation or treatment. She said if suspected over dose by resident having drugs on themselves if history of Substance abuse there may be an order of Narcan. In an observation on [DATE] at 11:18 a.m. MA J eMAR pulled up for one resident at a time. eMAR states hydrocodone/acetaminophen 1 tablet every six hours not prn. Narcotic sheet and med tablet pulled out. MA confirmed and verified medication with eMAR. Popped in medication into a medication cup and given to resident. Resident pain level 8.5 out of 10, 4 tablets remaining in blister pack. In an interview on [DATE] at 10:40 a.m. LVN K said she does not share a cart with anyone during the day. Before giving out narcotic, ask why they are asking, where the pain is, pain scale, check eMAR for when the last time medication was administered, check orders on eMAR, and on the card to verify how it is to be administered, document reason and for how much pain, verify the times match in eMAR and narcotic sheet to confirm its correct, check pills before administering. Only give if prn, but no more for the day. In an interview on [DATE] at 10:49 a.m. MA G said Last in-service was yesterday over the phone on the 5 rights, right time, right dose, right documentation, right route, right medication. Gives narcotics at noon and 1 pm, they are not prn. Check eMaR, check resident room and information 3 times, and sign out the time given. Explain to the resident what it is, locking everything up, sanitize and give to resident. In an interview on [DATE] at 11:52 a.m. CNA Z said she has been at the facility for two months. Last in-service was this past week on, abuse and neglect. The different types of physical, sexual, emotional, mental, and misappropriation of funds. She has not ever witne[TRUNCATED]

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on 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 for 1 of 5 residents (CR #1) reviewed for pharmacy services in that:. The facility failed to ensure CR #1 did not receive Hydrocodone-Acetaminophen (Norco) after it was discontinued after her hospital visit on [DATE] but was not discontinued in her chart. CR #1 received Norco more frequently than the order that remained in her chart on [DATE]. She experienced lethargy, nausea, vomiting, and decreased response to stimuli and expired at the hospital later that evening. An Immediate Jeopardy was identified on [DATE] at 4:33 p.m. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place the resident at risk for not receiving medications as ordered resulting in serious injury, decline in health, and death. Findings included: Record review of CR #1's admission record dated [DATE] revealed a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included hypotension (low blood pressure), muscle weakness, type 2 diabetes, end stage renal disease, dependence on renal dialysis, other abnormalities of gait and mobility, need for assistance with personal care, and chronic embolism and thrombosis of other specified veins (conditions involving persistent blood clots that can obstruct blood flow). Record review of CR #1's Discharge MDS assessment-return anticipated dated [DATE] revealed her cognitive skills for daily decision making were moderately impaired. She required assistance from staff with ADL care. Record review of CR #1's care plan dated [DATE] revealed the resident was full code (providing chest compressions in the event of cardia arrest). Interventions were to monitor for decrease in change of condition and report to the MD and responsible party. Record review of CR #1's Nursing note dated [DATE] written by LVN G read in part, During morning assessment resident noted to be lethargic and not answering nurse when asking question resident eyes PERRLA aroused to touch . BP 130/86 P 87 MD made aware new orders received for stat labs CBC/BMP labs were collected. Resident went to dialysis BP was low Midodrine was given BP went up to 108/67 then started dropping again . (family) came to visit resident stated resident looks worse then [sic] yesterday and wanted her sent to ER MD made aware of family request and called for preferred to pickup . (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's hospital record dated [DATE] -[DATE] read in part, .chief complaint: weakness - generalized pt from (facility) and report pt has been getting weaker for several days .ED course . [DATE] at 11:32 p.m. Pt more alert on re eval, counseled on findings. Suspect that her symptoms may be due to Norco. Counseled on cessation of Norco for the next few days . Final Diagnoses: generalized weakness . Medication changes: Hydrocodone/acetaminophen 10-325 mg 1 tablet every 6 hours prn (there was a line struck through it). Record review of CR #1's nursing note dated [DATE] written by LVN N read in part, .resident return from hospital this morning aprx, 0530 (5:30 a.m.), via ambulance . resident stable, no c/o pain or discomfort noted at time of arrival . discharge instructions include DC of Norco 10-325 no other changes to medications made . Record review of CR #1's Order Summary Report dated [DATE] revealed an order for Hydrocodone-Acetaminophen (Norco) 10-325 mg 1 tablet by mouth every 6 hours as needed for pain, order date [DATE], discontinued [DATE]. Record review of CR #1's Medication Administration Record for [DATE] revealed Hydrocodone-Acetaminophen 10-325 mg 1 tablet every 6 hours as needed for pain was documented as administered on [DATE] at 8:10 a.m. There was no other administration documented on [DATE] for Hydrocodone-Acetaminophen. Record review of CR #1's Controlled Drug Administration Record for Hydrocodone-Acetaminophen (Norco) 10-325 mg dated [DATE] revealed one tablet was documented as administered to CR #1 on 4/4/(24) at 6 a. m. by LVN D and another tablet was documented as administered 2 hours later on 4/4/(24) at 8 a.m. by LVN J. Record review of CR #1's nursing note dated [DATE] at 12:38 p.m. written by LVN J read in part, 'Resident is drowsy; Norco's overdose noted. Resident has refused meals: breakfast and lunch. Monitoring in progress. Record review of CR #1's nursing note dated [DATE] at 12:56 p.m. written by the previous DON read in part, DON was called to resident's room due to resident being drowsy after returning from dialysis around on assessment resident was arousable and verbally responsive stating she was tired and wants to sleep. Charge Nurse stated resident was given PRN Norco before going to dialysis. Record review indicated resident was given an extra dose of Norco 2 hours after the previous dose instead of every 6 hours. MD made aware. MD instructed to monitor resident for responsiveness. Record review of a text message conversation provided by the facility with MD R dated [DATE] at 12:56 p.m. read, Also (CR #1) can [sic] given Norco sooner 2 hours apart instead of 6 hrs because night did not document in emar that she gave a dose a 6 pm [sic]. Morning nurse gave it again when resident asked for pain meds. She is talking but more sleepy . MD R responded, Yes she can have the early dose. Record review of CR #1's nursing note dated [DATE] at 3:06 p.m. written by LVN J read in part, Resident has nausea and vomiting. Change of condition. Has called physician for new order. Message left via voicemail. Record review of CR #1's vital signs on [DATE] at 3:36 p.m. revealed her blood pressure was 80/57 mmHg. Her respirations were 16 breaths/minute and oxygen was 96% on [DATE] at 2:11 p.m. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's nursing note dated [DATE] at 6:19 p.m. written by LVN D read Patient administer oxygen per nasal canula at 3L. The EMS received vital signs and decided to transport patient for acute care . Record review of CR #1's nursing note dated [DATE] at 8:18 p.m. written by LVN D read, Upon attempting to administer patient scheduled medication, patient appears to have increased lethargy. O2 level obtained at 90% on RA upon assessment. Patient sternal rubbed and minimally responsive to stimuli. EMS Service contacted for acute care transport to ED. Pt assessed via 6 EMS transport to (hospital). Record review of CR #1's hospital records dated [DATE] read in part, .Patient presents with cardiac arrest . EMS reports (facility) staff stated pt was in respiratory distress all day and progressively getting worse. Per EMS pt was having agonal breaths upon arrival to scene and pt went inyo [sic] cardiac arrest on ambulance. Patient downtime wa [sic] 1 minute before arrival to ED, no meds given en route Medical Decision Making . EMS reports they were called to the patient's nursing home due to severe respiratory distress, on their arrival patient was obtunded, severe respiratory distress, and route to ER patient became apneic and lost pulses and they started CPR. CPR was initiated 2 minutes prior to arrival . after 20 minutes of CPR, decision was made to terminate interventions. Time of death called at 9:09 p.m. Observation and Interview on [DATE] at 8:15 a.m. revealed that one tablet of Senna 8.6 mg was administered by MA G to Resident #59 and Folic Acid was not administered to Resident #59. MA G said that the medication was not available and came from the pharmacy. In a telephone interview on [DATE] at 10:38 a.m. the previous DON said the night nurse administered Norco to CR #1 prior to leaving her shift and documented it in the narcotic book but did not document it in the eMAR. She said the morning nurse arrived and the resident asked for pain medicine, and he administered the same medication within 2 hours instead of 6 hours. She said the Norco was scheduled for every 6 hours. She said the facility notified MD R and he said it was not a problem and ok to give the medication sooner and to just keep an eye on her. She said she could not recall if CR #1 had an order for the Norco. She said CR #1 was a little sleepy but was herself and they monitored her. She said CR #1 was in and out of the hospital very frequently and did not remember if she went out to the hospital that day. She said she in serviced LVN J who was an agency nurse and did not allow him to come back to the facility. She said staff should document administered narcotics in both the eMAR and narcotic book because there could be a risk of double dosing the resident. In an interview on [DATE] at 10:53 a.m. CR #1's family member said the resident admitted to the facility for rehabilitation. He said hospital staff informed him a few times that CR #1 was overmedicated with pain medication. He said when he visited her at the facility, she was not all the way there, she was in and out, more quiet, exhausted, and not there at all. He said she deteriorated at the facility and was never like that before. He said on [DATE] he went to the facility to check on her and she was particularly out of it that day. Her body was cold, she was responsive but was in and out. He said she vomited on herself around 11:30 a. m. - 12:30 p.m. He reported it and staff arrived but did not ask about the vomiting. He said she went to sleep and later that evening around 10:45 p.m. the facility called another family member to inform her she was at the local hospital and her oxygen was low, but blood pressure was fine. He said when he arrived at the ER he was met with an empty room and a body bag on top of the gurney. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on [DATE] at 11:16 a.m. LVN D said she did not remember a possible overdose and did not remember sending CR #1 to the hospital. In a telephone interview on [DATE] at 11:38 a.m. MD R said CR #1 went to the hospital on 3/22-23/24 due to generalized weakness. He said if the Norco was supposed to be stopped the facility should reconcile with the MD and it should be stopped but said he was not sure if it was discontinued because he did not see the DC in the hospital records. He said the ED recommended to stop CR #1's Norco due to weakness, not from overdosing. He said he was unsure if he was notified of the Norco overdose (on [DATE]). He said the risk of a Norco overdose would depend on the patient and monitoring was important. He said CR #1 had ESRD and should be monitored pretty closely. In a telephone interview on [DATE] at 12:02 p.m. MD G said she did not recall the incident and was not notified of anything regarding CR #1. She said if the Norco order was for every 6 hours she did not know why it was administered in 2 hours. She said Norco could upset the stomach and lethargy could happen if Norco was given too early. In an interview on [DATE] at 12:15 p.m. the Regional Nurse said she was unsure of when the facility stopped using nursing agencies. She said she was unsure of anything that happened to CR #1, only what was in the chart. She said the expectation was for nurses to document when giving the medication to the residents and they should follow the order as prescribed. If there was a change in condition the resident should be assessed, and the physician notified and documented. If the physician did not respond, staff should call back and if no response, the medical director is to be called. Depending on the status of the resident, if the resident was in respiratory distress or vital signs too low or high, staff could use nursing judgement for the resident's safety. For medication pass, it is documented on the eMAR and the narcotic count book/log. If doing medication pass, both the eMAR and narcotic book should be reviewed before administering the medication. When residents return from the hospital the discharge summary is reviewed by the nurse who is accepting the resident. The nurse will then input the discharge summary into PCC. They are checking the medications are input correctly into PCC. They are to verify the orders with the attending doctor to ensure they agree for the resident's care. If a resident is given discontinued medication, they did not follow the MD orders and the resident could be at risk. She noticed when the resident came back from the hospital, the nurse wrote D/C Norco, but it was not discontinued. She did not review the discharge hospital summary. She also read that the resident received extra Norco. Per the notes, the resident was lethargic and not as responsive. She did know she had cardiac arrest and passed away. She did not believe the extra Norco caused CR #1's death. She was unsure if the resident was to be on the Norco but noticed that it was discontinued, and did not know why. She did read the resident asked to go to the hospital previously to get Morphine. Record review of the discontinued medications policy, states the nurse documents the order to discontinue the medication in the resident's record. The Physician's order sheet (POS) and the medication administration record (MAR) are updated to indicate that the order is discontinued. Alternatively, the discontinuation order is entered into the facility's EHR system. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the general guidelines for medication administration policy, states always employ the MAR during medication administration. Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. Record review of Change in condition policy, states that once the nurse has notified the physician for a change in condition the resident/patient will be monitored for 1 hour until the physician has responded. The monitoring will include vital signs, pulse ox, and finger stick blood sugar if diabetic (one time only). A physical assessment should be completed relative to the symptoms present and a pain assessment. If resident/patient condition appears emergent transfer to local ER may occur without physician order. On [DATE] at 4:33 p.m. the regional nurse and administrator were informed that an Immediate Jeopardy situation was identified due to the above failures and a Plan of Removal was requested. The following Plan of Removal was submitted by the facility and accepted on [DATE] at 9:47 p.m. On [DATE] an investigation survey was initiated. On [DATE] the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to ensure CR #1 did not receive Hydrocodone-Acetaminophen more frequently than prescribed by the MD on [DATE]. Resident CR#1 was discharged to the hospital on [DATE] and expired due to Cardiac Arrest. Charge Nurse (LVN/RN) will receive education and/or disciplinary action if medication administration is not documented in MAR and Narcotic Control log for all Narcotic medications. Charge Nurse J was in serviced on 4/4 on medication administration and followed physician orders by director of nursing. The nurse was an agency nurse, and we will never select to use this nurse again. Facility's Plan to ensure compliance quickly. Tag cited: F-760 oOn [DATE] Regional Nurse initiated Inservice with Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on Following of Physician Orders. The in-service reads: Medications are to be administered as ordered by MD. PRN Narcotic medication is to be documented on MAR and Narcotic Control Log. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. This in-service is to be completed on [DATE]. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	oOn [DATE] Regional Nurse initiated Inservice with Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on Medication Administration. The in-service reads: Charge nurses (LVN/RN) and Certified Medication Aides are to follow the 5 rights of medication administration. Right medication, Right patient, Right Dosage, Right Route, Right Time. All nursing staff expected to be in-serviced prior to the next shift worked. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. This in-service is to be completed on [DATE]. oOn [DATE] Regional Nurse initiated Inservice with Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on Change in Condition. The in-service reads: Resident noted with a change in condition is to be assessed by nurse and Md must be notified. Residents continue to be assessed if physician is unable to be reached within 2 hours repeat call and involve medical director. If resident condition appears emergent send to ER. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and Agency staff. This in-service is to be completed on [DATE]. oOn [DATE] Regional Nurse initiated Inservice with Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on Medication Errors. The in-service reads: Physician is to be notified of all medication errors and resident is to be monitored closely for any adverse reactions. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and Agency staff. This in-service is to be completed on [DATE]. oRegional Nurse/Designee initiated medication pass competency check offs on Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. Agency Staff medication pass competency to be completed at start of shift. This observation is to be completed on [DATE]. oAudit conducted on [DATE] of residents PRN narcotics orders to ensure MARS reflects medications are administered as indicated by physician orders for the past 30 days. On [DATE] MAR to Narcotic count sheet check completed to confirm medications are documented on MAR and Narcotic log. There are no indications of medication errors from the audit. Completed on [DATE]. oThe Medical Director has been notified on [DATE] of immediate jeopardy and reviewed the current change in condition policy and procedures, following physician order policy and procedure, medication administration policy and procedure, and medication error policy and procedure. Plan of action reviewed with the Medical Director with no changes to the current policies. This practice will be reviewed monthly with the QA committee to ensure we are compliant with the change in condition policy and procedures, medication administration policy and procedure, and medication error policy and procedure. Start Date: [DATE]. Completion Date: [DATE] (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Responsible: Regional Nurse/Designee Monitoring was conducted on [DATE] and [DATE] to verify the facility's plan of removal. The monitoring included: Record review of Dialyzable drugs - acetaminophen was listed, but did not affect toxicity. Hydrocodone was not listed. (Dialyzable drugs are drugs that can be removed by dialysis). Record review of In-service dated [DATE] with previous DON- transcribing medication orders in PCC. Following Hospital Medication orders; clarification and confirming orders. Identifying hazard drug alert on EMAR and blister pack. Record review of In-service dated [DATE] at 6 p.m. with previous DON - for medication administration, pain *unreadable* meds as you go in EMAR. Narcotics should be divided in eMAR and also documented in narcotic log. Record review of In-service & Education Record dated [DATE] - Description: Nurses/CMAs to follow MD orders when administering meds. Review discharge summary from hospital for current med reconciliation. Any medication that resident was receiving previously must be discontinued if not on hospital discharge summary. MD to be notified of admission and verification of meds. There were 9 signatures. Record review of Inservice & Education Record dated [DATE] - Inputting orders into PCC (an electronic medical record) - make sure order is accurate - 5 rights of med administration - order is assigned a schedule and is on correct MAR - all PRN meds go on nurses MAR (LMAR). There were 9 signatures Record review of Inservice & Education Record dated [DATE] - Medication is to be administered as ordered by the MD. Charge nurses are to follow the 5 rights of med administration - right med, right patient, right dosage, right route and right time. Staff not following the above will receive disciplinary action up to and including termination. There were 10 signatures (MA, RN, LVN) Record review of Inservice & Education Record dated [DATE] - Resident noted with a change in condition is to be assessed by the nurse and MD notified - res is to continue to be assessed if unable to reach physician within 2 hours. Repeat call - if you still cannot reach MD call the Medical Director - if resident/pt condition appears emergent send to ER. There were 8 nurse signatures. Record review of Inservice & Education Record dated [DATE] - Medication error - MD is to be notified of any medication error and resident is to be monitored for any adverse reactions. There were 8 nurse signatures. Record review of Inservice & Education Record dated [DATE] - PRN medications are to be documented on narcotic count sheet and on MAR in resident chart after medication administered. Resident to be assessed for pain with shift and document effectiveness of pain medication. There were 8 nurse signatures. Record review of Medication Pass Audits dated [DATE]. There were 5 audits conducted with no errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676204	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Inservice & Education Record dated [DATE] - Medication Administration, prn documentation, following 6 rights of medication pass, preventing medication errors. Check and balance of admission/discharge medication reconciliation, MD orders - PCC, notification of medication error to MD, med pass audit will be observed 1st day back to work before hitting the floor to pass meds. There were 4 nurse signatures. In an interview on [DATE] at 1:18 p.m. LVN B (Charge nurse 6 a.m. - 6 p.m.) said she was trained to document changes in condition, monitor, and follow up with the MD and Medical Director. If the situation was emergent, she would send them out so the patient is not compromised. The 5 rights of medication administration include to use the right medication, patient, route, time, and document pain on MAR and on narcotic sheet and ensure the times match too because it could be a medication error. She said you document a change in condition in the assessments einteract SBAR, notify the MD right away let them know what is going on, and notify the DON of changes. She said she would keep assessing the patient for any changes either better or worse and document if interventions have helped. She said PRN medications should be reassessed around 15-45 minutes later to ensure efficacy. If there was a medication error, she would notify the DON right away, go through the steps of what happened, do an investigation, notify the MD, assess the resident for adverse reactions, and monitor them very closely for any issues. She would monitor vital signs, alertness, cognition and compare to baseline. For hospital discharge orders she would verify the medications from the hospital with the MD and enter the medication in properly. She said if a medication was discontinued, she would discontinue medication from the system, put in a progress note, and remove medication from the cart. She said she had to do a medication pass with a staff member. She said the MD order would say how often you can administer the medication; she would go in the computer to see when it was last administered and to see if it was too soon or not. She said she also checked the narcotic book just in case it was not documented in the eMAR. In an interview on [DATE] at 1:32 p.m. RN B said the 5 rights of medication pass were to ensure the right person, route, dose, medication, and time. She said a medication pass was conducted. For change in condition, she would document and notify the MD, get a timely response and follow up, send the resident out to the hospital if necessary and report to MD and oncoming shift for follow up. She said she could also reach out to the DON and Administrator and follow up with the Medical Director on what needs to get done. If severe enough send out resident to 911. For hospital discharge orders she said she would reconcile the medication and compare what is new and notify MD who does the final reconciliation. For a change in condition she would assess for new pain, assess the vital signs, check alertness/change in cognition, notify findings to MD and follow orders. She would always do a progress note and look for a change in condition form. If there was a medication error, she would complete an incident report, document, and notify superiors, MD, RP, assess the patient for changes, adverse effects, signs and symptoms to watch for, and continue to monitor the resident. When administering prn narcotics, she would document the prn narcotic in PCC and narcotic log because they do not serve the same purpose. She said PCC showed when the medication was given last, and the narcotic log count sheet purpose was to obtain a proper count. (continued on next page)

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Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 1:52 p.m. LVN F (6 a.m. - 6 p.m.) said she was trained on documenting in the MAR and narcotic book when administering a prn medication so that you do not overdose but give the proper dosage. If there was a change in condition, she would notify the MD and if they did not respond within 2 hours she would go to the medical director, if emergent call 911, don't wait. She would document the change in condition under assessments with option for change in condition. She would determine the symptoms, if new or chronic, which body system did it pertain to, most recent vitals, and situation. She would monitor the resident and implement intervention. If the intervention did not work, she would notify the doctor again. For discharge hospital orders she said if a medication was not on the discharge list you could not give it and could not just go back to what they had prior to the hospital. She said she would reconcile the orders with the MD. She said the 5 rights of medication administration were - right patient, right dosage, right form, route, and time. She said every medication should have the right time if not, question the doctor. She said for a medication error she was trained to alert whoever was in charge, start monitoring for side effects such as respiratory depression, and notify the MD. She said she would monitor the resident for at least 24 hours depending on the drug. In an interview on [DATE] at 2:13 p.m. MA J (2 p.m. - 10 p.m.) said the 5 rights of medication administration were the right patient, medication, dose, time, and route. She said she was trained to follow MD orders. She said if the resident asked for pain medication that was already given, she would notify the nurse that it was already given. She said narcotic medication should be documented on the narcotic book and on the computer. In an interview on [DATE] at 7:46 p.m. LVN E said she had recent in services on medication administration, 5 rights of medication, identifying the patients, when to send residents out, and many others. When administering medications, she would first look up the patient and go over the eMAR, verify the order is correct, and current, then she would locate the medication and ensure the order is what she is supposed to give. She would do hand hygiene, identify pt by photo and by confirming with pt. then she would verify medication at bedside, check expiration date, look over eMAR, make sure it's the right medication, then administer medication. She would document the medication on the eMAR. As soon as she realized she gave the wrong medication, she would contact provider, get baseline set of vitals and monitor condition and mental status and continue to monitor for any change in condition. She would contact 911 if change in condition or if doctor orders her to send pt out. In an interview on [DATE] at 7:55 p.m. LVN C said she had in services on medication administration, when to contact Physician, RP, POA, change in condition in services. They were given yesterday. She said she knows the 5 rights, patient, drug, dose, routes, time, follow up effectiveness, allergies, when to notify MD and antibiotics and safety concerns. She would first identify pt, double check drug, drug label against eMAR, correct dose, correct route, and time, monitor for any adverse effects. She said that she would monitor vital signs, if suspected over dose, notify physician, DON, RP , and if critical or obstruction of airway, loss of conscious, then move to code status, notify hospice if necessary, make determination if sent out for evaluation or treatment. She said if suspected over dose by resident having drugs on themselves if history of Substance abuse there may be an order of Narcan. In an observation on [DATE] at 11:18 a.m. MA J eMAR pulled up for one resident at a time. eMAR states hydrocodone/acetaminophen 1 tablet every six hours not prn. Narcotic sheet and med tablet pulled out. MA confirmed and verified medication with eMAR. Popped in medication into a medication cup and given to resident. Resident pain level 8.5 out of 10, 4 tablets remaining in blister pack. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 10:40 a.m. LVN K said she does not share a cart with anyone during the day. Before giving out narcotic, ask why they are asking, where the pain is, pain scale, check eMAR for when the last time medication was administered, check orders on eMAR, and on the card to verify how it is to be administered, document reason and for how much pain, verify the times match in eMAR and narcotic sheet to confirm its correct, check pills before administering. Only give if prn, but no more for the day. In an interview on [DATE] at 10:49 a.m. MA G said Last in-service was yesterday over the phone on the 5 rights, right time, right dose, right documentation, right route, right medication. Gives narcotics at noon and 1 pm, they are not prn. Check eMaR, check resident room and information 3 times, and sign out the time given. Explain to the resident what it is, locking everything up, sanitize and give to re[TRUNCATED]

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 5 residents (CR #1) reviewed for significant medication errors. The facility failed to ensure CR #1 did not receive Hydrocodone-Acetaminophen (Norco) after it was discontinued after her hospital visit on [DATE] but was not discontinued in her chart. CR #1 received Norco more frequently than the order that remained in her chart on [DATE]. She experienced lethargy, nausea, vomiting, and decreased response to stimuli and expired at the hospital later that evening. An Immediate Jeopardy was identified on [DATE] at 4:33 p.m. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place the resident at risk for not receiving medications as ordered resulting in serious injury, decline in health, and death. Findings included: Record review of CR #1's admission record dated [DATE] revealed a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included hypotension (low blood pressure), muscle weakness, type 2 diabetes, end stage renal disease, dependence on renal dialysis, other abnormalities of gait and mobility, need for assistance with personal care, and chronic embolism and thrombosis of other specified veins (conditions involving persistent blood clots that can obstruct blood flow). Record review of CR #1's Discharge MDS assessment-return anticipated dated [DATE] revealed her cognitive skills for daily decision making were moderately impaired. She required assistance from staff with ADL care. Record review of CR #1's care plan dated [DATE] revealed the resident was full code (providing chest compressions in the event of cardia arrest). Interventions were to monitor for decrease in change of condition and report to the MD and responsible party. Record review of CR #1's Nursing note dated [DATE] written by LVN G read in part, During morning assessment resident noted to be lethargic and not answering nurse when asking question resident eyes PERRLA aroused to touch . BP 130/86 P 87 MD made aware new orders received for stat labs CBC/BMP labs were collected. Resident went to dialysis BP was low Midodrine was given BP went up to 108/67 then started dropping again . (family) came to visit resident stated resident looks worse then [sic] yesterday and wanted her sent to ER MD made aware of family request and called for preferred to pickup . (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's hospital record dated [DATE] -[DATE] read in part, .chief complaint: weakness - generalized pt from (facility) and report pt has been getting weaker for several days .ED course . [DATE] at 11:32 p.m. Pt more alert on re eval, counseled on findings. Suspect that her symptoms may be due to Norco. Counseled on cessation of Norco for the next few days . Final Diagnoses: generalized weakness . Medication changes: Hydrocodone/acetaminophen 10-325 mg 1 tablet every 6 hours prn (there was a line struck through it). Record review of CR #1's nursing note dated [DATE] written by LVN N read in part, .resident return from hospital this morning aprx, 0530 (5:30 a.m.), via ambulance . resident stable, no c/o pain or discomfort noted at time of arrival . discharge instructions include DC of Norco 10-325 no other changes to medications made . Record review of CR #1's Order Summary Report dated [DATE] revealed an order for Hydrocodone-Acetaminophen (Norco) 10-325 mg 1 tablet by mouth every 6 hours as needed for pain, order date [DATE], discontinued [DATE]. Record review of CR #1's Medication Administration Record for [DATE] revealed Hydrocodone-Acetaminophen 10-325 mg 1 tablet every 6 hours as needed for pain was documented as administered on [DATE] at 8:10 a.m. There was no other administration documented on [DATE] for Hydrocodone-Acetaminophen. Record review of CR #1's Controlled Drug Administration Record for Hydrocodone-Acetaminophen (Norco) 10-325 mg dated [DATE] revealed one tablet was documented as administered to CR #1 on 4/4/(24) at 6 a. m. by LVN D and another tablet was documented as administered 2 hours later on 4/4/(24) at 8 a.m. by LVN J. Record review of CR #1's nursing note dated [DATE] at 12:38 p.m. written by LVN J read in part, 'Resident is drowsy; Norco's overdose noted. Resident has refused meals: breakfast and lunch. Monitoring in progress. Record review of CR #1's nursing note dated [DATE] at 12:56 p.m. written by the previous DON read in part, DON was called to resident's room due to resident being drowsy after returning from dialysis around on assessment resident was arousable and verbally responsive stating she was tired and wants to sleep. Charge Nurse stated resident was given PRN Norco before going to dialysis. Record review indicated resident was given an extra dose of Norco 2 hours after the previous dose instead of every 6 hours. MD made aware. MD instructed to monitor resident for responsiveness. Record review of a text message conversation provided by the facility with MD R dated [DATE] at 12:56 p.m. read, Also (CR #1) can [sic] given Norco sooner 2 hours apart instead of 6 hrs because night did not document in emar that she gave a dose a 6 pm [sic]. Morning nurse gave it again when resident asked for pain meds. She is talking but more sleepy . MD R responded, Yes she can have the early dose. Record review of CR #1's nursing note dated [DATE] at 3:06 p.m. written by LVN J read in part, Resident has nausea and vomiting. Change of condition. Has called physician for new order. Message left via voicemail. Record review of CR #1's vital signs on [DATE] at 3:36 p.m. revealed her blood pressure was 80/57 mmHg. Her respirations were 16 breaths/minute and oxygen was 96% on [DATE] at 2:11 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676204	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's nursing note dated [DATE] at 6:19 p.m. written by LVN D read Patient administer oxygen per nasal canula at 3L. The EMS received vital signs and decided to transport patient for acute care . Record review of CR #1's nursing note dated [DATE] at 8:18 p.m. written by LVN D read, Upon attempting to administer patient scheduled medication, patient appears to have increased lethargy. O2 level obtained at 90% on RA upon assessment. Patient sternal rubbed and minimally responsive to stimuli. EMS Service contacted for acute care transport to ED. Pt assessed via 6 EMS transport to (hospital). Record review of CR #1's hospital records dated [DATE] read in part, .Patient presents with cardiac arrest . EMS reports (facility) staff stated pt was in respiratory distress all day and progressively getting worse. Per EMS pt was having agonal breaths upon arrival to scene and pt went inyo [sic] cardiac arrest on ambulance. Patient downtime wa [sic] 1 minute before arrival to ED, no meds given en route Medical Decision Making . EMS reports they were called to the patient's nursing home due to severe respiratory distress, on their arrival patient was obtunded, severe respiratory distress, and route to ER patient became apneic and lost pulses and they started CPR. CPR was initiated 2 minutes prior to arrival . after 20 minutes of CPR, decision was made to terminate interventions. Time of death called at 9:09 p.m. In a telephone interview on [DATE] at 10:38 a.m. the previous DON said the night nurse administered Norco to CR #1 prior to leaving her shift and documented it in the narcotic book but did not document it in the eMAR. She said the morning nurse arrived and the resident asked for pain medicine, and he administered the same medication within 2 hours instead of 6 hours. She said the Norco was scheduled for every 6 hours. She said the facility notified MD R and he said it was not a problem and ok to give the medication sooner and to just keep an eye on her. She said she could not recall if CR #1 had an order for the Norco. She said CR #1 was a little sleepy but was herself and they monitored her. She said CR #1 was in and out of the hospital very frequently and did not remember if she went out to the hospital that day. She said she in serviced LVN J who was an agency nurse and did not allow him to come back to the facility. She said staff should document administered narcotics in both the eMAR and narcotic book because there could be a risk of double dosing the resident. In an interview on [DATE] at 10:53 a.m. CR #1's family member said the resident admitted to the facility for rehabilitation. He said hospital staff informed him a few times that CR #1 was overmedicated with pain medication. He said when he visited her at the facility, she was not all the way there, she was in and out, more quiet, exhausted, and not there at all. He said she deteriorated at the facility and was never like that before. He said on [DATE] he went to the facility to check on her and she was particularly out of it that day. Her body was cold, she was responsive but was in and out. He said she vomited on herself around 11:30 a. m. - 12:30 p.m. He reported it and staff arrived but did not ask about the vomiting. He said she went to sleep and later that evening around 10:45 p.m. the facility called another family member to inform her she was at the local hospital and her oxygen was low, but blood pressure was fine. He said when he arrived at the ER he was met with an empty room and a body bag on top of the gurney. In a telephone interview on [DATE] at 11:16 a.m. LVN D said she did not remember a possible overdose and did not remember sending CR #1 to the hospital. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on [DATE] at 11:38 a.m. MD R said CR #1 went to the hospital on 3/22-23/24 due to generalized weakness. He said if the Norco was supposed to be stopped the facility should reconcile with the MD and it should be stopped but said he was not sure if it was discontinued because he did not see the DC in the hospital records. He said the ED recommended to stop CR #1's Norco due to weakness, not from overdosing. He said he was unsure if he was notified of the Norco overdose (on [DATE]). He said the risk of a Norco overdose would depend on the patient and monitoring was important. He said CR #1 had ESRD and should be monitored pretty closely. In a telephone interview on [DATE] at 12:02 p.m. MD G said she did not recall the incident and was not notified of anything regarding CR #1. She said if the Norco order was for every 6 hours she did not know why it was administered in 2 hours. She said Norco could upset the stomach and lethargy could happen if Norco was given too early. In an interview on [DATE] at 12:15 p.m. the Regional Nurse said she was unsure of when the facility stopped using nursing agencies. She said she was unsure of anything that happened to CR #1, only what was in the chart. She said the expectation was for nurses to document when giving the medication to the residents and they should follow the order as prescribed. If there was a change in condition the resident should be assessed, and the physician notified and documented. If the physician did not respond, staff should call back and if no response, the medical director is to be called. Depending on the status of the resident, if the resident was in respiratory distress or vital signs too low or high, staff could use nursing judgement for the resident's safety. For medication pass, it is documented on the eMAR and the narcotic count book/log. If doing medication pass, both the eMAR and narcotic book should be reviewed before administering the medication. When residents return from the hospital the discharge summary is reviewed by the nurse who is accepting the resident. The nurse will then input the discharge summary into PCC. They are checking the medications are input correctly into PCC. They are to verify the orders with the attending doctor to ensure they agree for the resident's care. If a resident is given discontinued medication, they did not follow the MD orders and the resident could be at risk. She noticed when the resident came back from the hospital, the nurse wrote D/C Norco, but it was not discontinued. She did not review the discharge hospital summary. She also read that the resident received extra Norco. Per the notes, the resident was lethargic and not as responsive. She did know she had cardiac arrest and passed away. She did not believe the extra Norco caused CR #1's death. She was unsure if the resident was to be on the Norco but noticed that it was discontinued, and did not know why. She did read the resident asked to go to the hospital previously to get Morphine. Record review of the discontinued medications policy, states the nurse documents the order to discontinue the medication in the resident's record. The Physician's order sheet (POS) and the medication administration record (MAR) are updated to indicate that the order is discontinued. Alternatively, the discontinuation order is entered into the facility's EHR system. Record review of the general guidelines for medication administration policy, states always employ the MAR during medication administration. Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Change in condition policy, states that once the nurse has notified the physician for a change in condition the resident/patient will be monitored for 1 hour until the physician has responded. The monitoring will include vital signs, pulse ox, and finger stick blood sugar if diabetic (one time only). A physical assessment should be completed relative to the symptoms present and a pain assessment. If resident/patient condition appears emergent transfer to local ER may occur without physician order. On [DATE] at 4:33 p.m. the regional nurse and administrator were informed that an Immediate Jeopardy situation was identified due to the above failures and a Plan of Removal was requested. The following Plan of Removal was submitted by the facility and accepted on [DATE] at 9:47 p.m. On [DATE] an investigation survey was initiated. On [DATE] the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to ensure CR #1 did not receive Hydrocodone-Acetaminophen more frequently than prescribed by the MD on [DATE]. Resident CR#1 was discharged to the hospital on [DATE] and expired due to Cardiac Arrest. Charge Nurse (LVN/RN) will receive education and/or disciplinary action if medication administration is not documented in MAR and Narcotic Control log for all Narcotic medications. Charge Nurse J was in serviced on 4/4 on medication administration and followed physician orders by director of nursing. The nurse was an agency nurse, and we will never select to use this nurse again. Facility's Plan to ensure compliance quickly. oOn [DATE] Regional Nurse initiated Inservice with Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on Following of Physician Orders. The in-service reads: Medications are to be administered as ordered by MD. PRN Narcotic medication is to be documented on MAR and Narcotic Control Log. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. This in-service is to be completed on [DATE]. oOn [DATE] Regional Nurse initiated Inservice with Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on Medication Administration. The in-service reads: Charge nurses (LVN/RN) and Certified Medication Aides are to follow the 5 rights of medication administration. Right medication, Right patient, Right Dosage, Right Route, Right Time. All nursing staff expected to be in-serviced prior to the next shift worked. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. This in-service is to be completed on [DATE]. (continued on next page)

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	676204	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	oOn [DATE] Regional Nurse initiated Inservice with Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on Change in Condition. The in-service reads: Resident noted with a change in condition is to be assessed by nurse and Md must be notified. Residents continue to be assessed if physician is unable to be reached within 2 hours repeat call and involve medical director. If resident condition appears emergent send to ER. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and Agency staff. This in-service is to be completed on [DATE]. oOn [DATE] Regional Nurse initiated Inservice with Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on Medication Errors. The in-service reads: Physician is to be notified of all medication errors and resident is to be monitored closely for any adverse reactions. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and Agency staff. This in-service is to be completed on [DATE]. oRegional Nurse/Designee initiated medication pass competency check offs on Nursing Staff (Assistant Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. Agency Staff medication pass competency to be completed at start of shift. This observation is to be completed on [DATE]. oAudit conducted on [DATE] of residents PRN narcotics orders to ensure MARS reflects medications are administered as indicated by physician orders for the past 30 days. On [DATE] MAR to Narcotic count sheet check completed to confirm medications are documented on MAR and Narcotic log. There are no indications of medication errors from the audit. Completed on [DATE]. oThe Medical Director has been notified on [DATE] of immediate jeopardy and reviewed the current change in condition policy and procedures, following physician order policy and procedure, medication administration policy and procedure, and medication error policy and procedure. Plan of action reviewed with the Medical Director with no changes to the current policies. This practice will be reviewed monthly with the QA committee to ensure we are compliant with the change in condition policy and procedures, medication administration policy and procedure, and medication error policy and procedure. Start Date: [DATE]. Completion Date: [DATE] Responsible: Regional Nurse/Designee Monitoring was conducted on [DATE] and [DATE] to verify the facility's plan of removal. The monitoring included: Record review of Dialyzable drugs - acetaminophen was listed, but did not affect toxicity. Hydrocodone was not listed. (Dialyzable drugs are drugs that can be removed by dialysis). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of In-service dated [DATE] with previous DON- transcribing medication orders in PCC. Following Hospital Medication orders; clarification and confirming orders. Identifying hazard drug alert on EMAR and blister pack. Record review of In-service dated [DATE] at 6 p.m. with previous DON - for medication administration, pain *unreadable* meds as you go in EMAR. Narcotics should be divided in eMAR and also documented in narcotic log. Record review of In-service & Education Record dated [DATE] - Description: Nurses/CMAs to follow MD orders when administering meds. Review discharge summary from hospital for current med reconciliation. Any medication that resident was receiving previously must be discontinued if not on hospital discharge summary. MD to be notified of admission and verification of meds. There were 9 signatures. Record review of Inservice & Education Record dated [DATE] - Inputting orders into PCC (an electronic medical record) - make sure order is accurate - 5 rights of med administration - order is assigned a schedule and is on correct MAR - all PRN meds go on nurses MAR (LMAR). There were 9 signatures Record review of Inservice & Education Record dated [DATE] - Medication is to be administered as ordered by the MD. Charge nurses are to follow the 5 rights of med administration - right med, right patient, right dosage, right route and right time. Staff not following the above will receive disciplinary action up to and including termination. There were 10 signatures (MA, RN, LVN) Record review of Inservice & Education Record dated [DATE] - Resident noted with a change in condition is to be assessed by the nurse and MD notified - res is to continue to be assessed if unable to reach physician within 2 hours. Repeat call - if you still cannot reach MD call the Medical Director - if resident/pt condition appears emergent send to ER. There were 8 nurse signatures. Record review of Inservice & Education Record dated [DATE] - Medication error - MD is to be notified of any medication error and resident is to be monitored for any adverse reactions. There were 8 nurse signatures. Record review of Inservice & Education Record dated [DATE] - PRN medications are to be documented on narcotic count sheet and on MAR in resident chart after medication administered. Resident to be assessed for pain with shift and document effectiveness of pain medication. There were 8 nurse signatures. Record review of Medication Pass Audits dated [DATE]. There were 5 audits conducted with no errors. Record review of Inservice & Education Record dated [DATE] - Medication Administration, prn documentation, following 6 rights of medication pass, preventing medication errors. Check and balance of admission/discharge medication reconciliation, MD orders - PCC, notification of medication error to MD, med pass audit will be observed 1st day back to work before hitting the floor to pass meds. There were 4 nurse signatures. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 1:18 p.m. LVN B (Charge nurse 6 a.m. - 6 p.m.) said she was trained to document changes in condition, monitor, and follow up with the MD and Medical Director. If the situation was emergent, she would send them out so the patient is not compromised. The 5 rights of medication administration include to use the right medication, patient, route, time, and document pain on MAR and on narcotic sheet and ensure the times match too because it could be a medication error. She said you document a change in condition in the assessments einteract SBAR, notify the MD right away let them know what is going on, and notify the DON of changes. She said she would keep assessing the patient for any changes either better or worse and document if interventions have helped. She said PRN medications should be reassessed around 15-45 minutes later to ensure efficacy. If there was a medication error, she would notify the DON right away, go through the steps of what happened, do an investigation, notify the MD, assess the resident for adverse reactions, and monitor them very closely for any issues. She would monitor vital signs, alertness, cognition and compare to baseline. For hospital discharge orders she would verify the medications from the hospital with the MD and enter the medication in properly. She said if a medication was discontinued, she would discontinue medication from the system, put in a progress note, and remove medication from the cart. She said she had to do a medication pass with a staff member. She said the MD order would say how often you can administer the medication; she would go in the computer to see when it was last administered and to see if it was too soon or not. She said she also checked the narcotic book just in case it was not documented in the eMAR. In an interview on [DATE] at 1:32 p.m. RN B said the 5 rights of medication pass were to ensure the right person, route, dose, medication, and time. She said a medication pass was conducted. For change in condition, she would document and notify the MD, get a timely response and follow up, send the resident out to the hospital if necessary and report to MD and oncoming shift for follow up. She said she could also reach out to the DON and Administrator and follow up with the Medical Director on what needs to get done. If severe enough send out resident to 911. For hospital discharge orders she said she would reconcile the medication and compare what is new and notify MD who does the final reconciliation. For a change in condition she would assess for new pain, assess the vital signs, check alertness/change in cognition, notify findings to MD and follow orders. She would always do a progress note and look for a change in condition form. If there was a medication error, she would complete an incident report, document, and notify superiors, MD, RP, assess the patient for changes, adverse effects, signs and symptoms to watch for, and continue to monitor the resident. When administering prn narcotics, she would document the prn narcotic in PCC and narcotic log because they do not serve the same purpose. She said PCC showed when the medication was given last, and the narcotic log count sheet purpose was to obtain a proper count. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 1:52 p.m. LVN F (6 a.m. - 6 p.m.) said she was trained on documenting in the MAR and narcotic book when administering a prn medication so that you do not overdose but give the proper dosage. If there was a change in condition, she would notify the MD and if they did not respond within 2 hours she would go to the medical director, if emergent call 911, don't wait. She would document the change in condition under assessments with option for change in condition. She would determine the symptoms, if new or chronic, which body system did it pertain to, most recent vitals, and situation. She would monitor the resident and implement intervention. If the intervention did not work, she would notify the doctor again. For discharge hospital orders she said if a medication was not on the discharge list you could not give it and could not just go back to what they had prior to the hospital. She said she would reconcile the orders with the MD. She said the 5 rights of medication administration were - right patient, right dosage, right form, route, and time. She said every medication should have the right time if not, question the doctor. She said for a medication error she was trained to alert whoever was in charge, start monitoring for side effects such as respiratory depression, and notify the MD. She said she would monitor the resident for at least 24 hours depending on the drug. In an interview on [DATE] at 2:13 p.m. MA J (2 p.m. - 10 p.m.) said the 5 rights of medication administration were the right patient, medication, dose, time, and route. She said she was trained to follow MD orders. She said if the resident asked for pain medication that was already given, she would notify the nurse that it was already given. She said narcotic medication should be documented on the narcotic book and on the computer. In an interview on [DATE] at 7:46 p.m. LVN E said she had recent in services on medication administration, 5 rights of medication, identifying the patients, when to send residents out, and many others. When administering medications, she would first look up the patient and go over the eMAR, verify the order is correct, and current, then she would locate the medication and ensure the order is what she is supposed to give. She would do hand hygiene, identify pt by photo and by confirming with pt. then she would verify medication at bedside, check expiration date, look over eMAR, make sure it's the right medication, then administer medication. She would document the medication on the eMAR. As soon as she realized she gave the wrong medication, she would contact provider, get baseline set of vitals and monitor condition and mental status and continue to monitor for any change in condition. She would contact 911 if change in condition or if doctor orders her to send pt out. In an interview on [DATE] at 7:55 p.m. LVN C said she had in services on medication administration, when to contact Physician, RP, POA, change in condition in services. They were given yesterday. She said she knows the 5 rights, patient, drug, dose, routes, time, follow up effectiveness, allergies, when to notify MD and antibiotics and safety concerns. She would first identify pt, double check drug, drug label against eMAR, correct dose, correct route, and time, monitor for any adverse effects. She said that she would monitor vital signs, if suspected over dose, notify physician, DON, RP , and if critical or obstruction of airway, loss of conscious, then move to code status, notify hospice if necessary, make determination if sent out for evaluation or treatment. She said if suspected over dose by resident having drugs on themselves if history of Substance abuse there may be an order of Narcan. In an observation on [DATE] at 11:18 a.m. MA J eMAR pulled up for one resident at a time. eMAR states hydrocodone/acetaminophen 1 tablet every six hours not prn. Narcotic sheet and med tablet pulled out. MA confirmed and verified medication with eMAR. Popped in medication into a medication cup and given to resident. Resident pain level 8.5 out of 10, 4 tablets remaining in blister pack. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 10:40 a.m. LVN K said she does not share a cart with anyone during the day. Before giving out narcotic, ask why they are asking, where the pain is, pain scale, check eMAR for when the last time medication was administered, check orders on eMAR, and on the card to verify how it is to be administered, document reason and for how much pain, verify the times match in eMAR and narcotic sheet to confirm its correct, check pills before administering. Only give if prn, but no more for the day. In an interview on [DATE] at 10:49 a.m. MA G said Last in-service was yesterday over the phone on the 5 rights, right time, right dose, right documentation, right route, right medication. Gives narcotics at noon and 1 pm, they are not prn. Check eMaR, check resident room and information 3 times, and sign out the time given. Explain to the resident what it is, locking everything up, sanitize and give to resident. In an interview on [DATE] at 11:52 a.m. CNA Z said she has been at the facility for two months. Last in-service was this past week on, abuse and neglect. The different types of physical, sexual, emotional, mental, and misappropriation of funds. She has not ever witnessed abuse or neglect at this facility. If suspected, it should be reported immediately to the nurse and DON and the abuse coordinator, [TRUNCATED]