STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676229	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trucare Living Centers-Columbus	1511 Montezuma Street Columbus, TX 78934

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for 1 of 6 residents (Resident #55) reviewed for supervision. -Resident #55 was observed with a skin tear on 02/04/2025 which she stated resulted from a CNA transferring the resident into bed. This failure could place residents at risk of being injured from being improperly transferred. Findings included: Record review of Resident #55's face sheet last captured on 02/06/2025 revealed an [AGE] year-old female originally admitted on [DATE]. Her medical diagnoses included Parkinson's Disease (a degenerative neurological disease-causing loss of motor function control), osteoarthritis (inflammation and pain at joints), hypertension (high blood pressure), vertigo (dizziness), intervertebral disc degeneration lumbar region (lower spine bone loss), muscle weakness, and general pain. Record review of Resident #55's Comprehensive MDS (a resident assessment tool) dated 11/13/2024 revealed a BIMS (Brief Interview for Mental Status) score of 15, meaning she was cognitively intact. Resident #55 was usually able to make herself understood and usually understood others. Resident #55 was documented having a wheelchair. She required some supervision with toileting and upper body dressing and partial assistance with transferring from the chair to bed and bed to chair and going to the toilet. Record review of Resident #55's care plan last reviewed 11/26/2024 revealed on 11/10/2023 she had an initiated focus area for being at risk for falls related to vertigo, muscle weakness and muscle spasms, with interventions including educating resident on using call light for assistance with ADLs and transfers and being monitored frequently for unspoken needs. Record review of Resident #55's progress notes revealed no documentation regarding her bruising or skin tear. Record review of Resident #55's weekly/monthly skin evaluation completed on 01/12/2025 revealed no skin concerns and no pain. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #55's Physician Orders revealed she had an order for monthly skin assessment every shift for one month starting on the 12th for 1 day with an order date of 03/14/2024. Record review of Resident #55's TAR (Treatment Administration Record) for January and February 2025 revealed she had no orders related to a skin tear or bruising. Record review of the facility's Incident and Accidents from 08/05/2025 to 02/05/2025 revealed no record of injuries for Resident #55. Observation and interview with Resident #55 on 02/04/2025 at 9:38 a.m., Resident #55 said she was doing well, and that staff treated her well. She was observed having a reddish bruise with purple outline on her left outer forearm shaped like a half-moon and had two white strips taped over another part of the bruise at the center of her forearm with a short black line drawn connecting both strips. The bruising appeared to be healing. She denied pain from the bruise. Resident #55 said she got the injury when a CNA was helping her from her wheelchair to the bed. The CNA told Resident #55 to hug her to help with the transfer and when Resident #55 reached for the aide, the aide's nails scratched her arm. Resident #55 said this incident happened the previous week on 01/30/2025. She said she was not complaining and did not want to disclose the CNA's name. She said no one had done any treatment on the injury since it was bandaged that night. A later observation and interview on 02/06/2025 at 10:50 a.m., she said that staff told her the two strips would fall out on its own, and she said she got the injury due to staff taking her to the restroom at night and it must've been the staff member's jewelry or nails that scratched her. Interview with LVN B on 02/06/2025 at 11:43 a.m., she said she was the treatment nurse as well. LVN A said head-to-toe skin assessments are done after incidents, monthly as scheduled, or if residents are triggered for pressure sources. LVN A was not aware of Resident #55's skin tear and said she would look at it. LVN A said CNAs have shower sheets and if they notice anything they'll add it on there and that would be reviewed by the DON and treatment nurse. Interview with CNA A on 02/06/2025 at 01:43pm, she said she worked with Resident #55 on 02/06/2025 and said she saw the two strips on her left arm but could not remember when she noticed it. She denied doing any documentation on Resident #55 as she was not under CNA A's direct care that day. Attempted interview with CNA C on 02/06/2025, she documented on 2/2/25 at 12:21a.m., that Resident #55 had no skin issues. The phone number did not have voicemail capabilities and the phone call was not returned. Interview with CNA D on 02/06/2025 at 12:23 pm, she documented on 01/31/2025 at 9:59 p.m., that Resident #55 had no skin issues. CNA D said Resident #55 had no changes in condition that she was aware of. She said she saw Resident #55's skin tear after she returned to work. CNA D asked Resident #55 told her someone took her to the restroom and accidentally scratched her. CNA D said she did not ask for further details, but that Resident #55 was in her right mind and could tell who did it. CNA D documented she had no skin issues because Resident #55 already brought up her skin tear to someone else. Interview with RN A on 02/06/2025 at 12:01 p.m., she was the evening shift nurse on 01/30/2025 for Resident #55's hall. RN A was not aware of Resident #55's skin tear and that Resident #55 did not talk to her about it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MA A on 02/06/2025 at 12:16 p.m., she was the medication aide on 01/30/2025 for evening shift. MA A denied seeing any bruising or injuries on Resident #55 and that if she saw anything she would've reported it. Interview with CNA B on 02/06/2025 at 01:51 p.m., she was the evening and night aide on 01/30/2025 for Resident #55's hall. She said she did not notice any bruising or skin tears on Resident #55 that night. She said Resident #55 could vocalize her needs. Interview with LVN A on 02/06/2025 at 2:30 p.m., she was the night shift nurse on 1/30/2025 for Resident #55's hall. She said that she was not aware of Resident #55's skin tear. Interview with the DON on 2/6/25 at 12:29 p.m., he said that he first heard of the skin tear on 02/06/2025. In a later interview on 02/06/2025 at 03:19 p.m., he said a risk to residents from not recognizing and documenting a skin tear would be an infection could happen later on. Interview with the Administrator on 02/06/2025 at 11:30 a.m., the facility did not have a policy on skin assessments. At a later interview on 04:49 p.m., she said that if Resident #55 was scratched by staff, she expected that it should be reported up so the wound care nurse could treat it and see if the facility needed to do any further action on it. The Administrator said that changes in condition should be reported to the charge nurse, and that a risk of not reporting would be a resident's decline. Record review of the facility's Charting and Documentation policy statement last revised 03/01/2022 read in part, All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical records. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care, which included objective observations, treatments or services performed, and changes in the resident's condition and events.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observations, interviews, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 10 % based on 2 errors out of 28 opportunities, which involved 3 of 4 residents (Resident # 47, #53 and Resident #63) reviewed for medication administration. 1. MA D failed to administer Citalopram (antidepressants is used to treat depression) to Resident #47, according to physician orders. 2. MA D failed to administer Refresh tear Ophthalmic solution (used to treat dry eyes) to Resident #53. MA D used Resident # 36's Systane (eyedrop used to lubricate the eyes and treat symptoms of dry eyes) to Resident # 53 These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: 1. Record review of Resident #47's face sheet dated 2/4/25 revealed a [AGE] year-old female with an admitted [DATE]. Resident #47 had diagnoses which included: acute on chronic systolic (congestive) heart failure (the left chamber of your heart responsible for pumping blood throughout the body is weakened over time and cannot squeeze hard enough to push out enough blood with each beat, causing symptoms like shortness of breath, fatigue and swelling in the legs) altered mental status, unspecified, age-related cognitive decline Record review of Resident #47's quarterly MDS dated ,d+[DATE]//24, BIMS score was not checked, which indicated the resident was severely impaired cognitively. Record review of Resident #47's current physicians orders revealed an order with a start date of 2/3/25, for Citalopram tab 10 mg 1 tablet po by mouth one time per day for anxiety at 08:00 AM. Record review of Resident #47's medication administration record (MAR) dated 2/3/25 reflected Citalopram tab 10 mg 1 tablet po by mouth one time per day for anxiety at 08:00 AM. MA D initialed as given on 2/4//25. During a medication administration observation on 2/4/25 at 8:20 AM for Resident #63, MA A dispensed one Citalopram tab 20 mg 1 tablet into a medication cup and administered the medication to Resident #47 by mouth. 2. Record review of Resident #53's face sheet dated 2/4/25 revealed a [AGE] year-old female with an admitted [DATE]. Resident #53 had diagnoses which included: multiple fractures of pelvis with stable disruption of pelvic ring, subsequent encounter for fracture with routine healing, dry eyes and glaucoma. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #53's admission MDS dated ,d+[DATE]//24, BIMS score was 7, which indicated the resident was moderately impaired cognitively. Record review of Resident #53's current physicians orders revealed an order with a start date of 1/22/25, for Refresh tear ophthalmic solution (Carboxymethylcellulose Sodium Ophthalmic) instill 2 drop in each eye, two times a day for dry eyes. Record review of Resident #53's medication administration record (MAR) dated 2/3/25 reflected Refresh tear ophthalmic solution (Carboxymethylcellulose Sodium Ophthalmic) Instill 2 drop in each eye, two times a day for dry eyes. MA A initialed as given on 2/4/25. During a medication administration observation on 2/4/25 at 9:24 AM for Resident #53, MA D picked up Systane Lubricant and instill 1 drop to each eye for Resident #53 belonging a Resident #36. Interview with MA D on 2/6/25 at 9:45 AM regarding not giving the right medication and using another Resident's medication, she said it was medication error she should have checked it several times before giving and she was nervous. During an interview on 2/6/25 at 4:21 PM, the DON said he expected the medications to be given as ordered. He said the resident could suffer decline or adverse side effects. He expected both the medication aides to give the medications as ordered. He would have to in-service MA's. DON was asked what would happen when rights dose of medication not given , DON said if the right dose of medication was not given, Residents would not receive the right strength of the medication for its effectiveness He said the pharmacist observed MA's with medication administration last month and sometimes the cooperate nurse does. DON was asked for the in-services the pharmacist and the corporate nurse did for medication aide but was not provided before exit. During an interview on 2/6/25 at 5:10 PM, the Administrator said she expected the staff to administer the medications per the physician's order. She said she expected the medication aide to notify the nurse and medication aides so that the doctor can get the medication that appropriate form. She said she expected the correct medication to be given. She said the resident could suffer harm as a result of errors in medication administration. Interview Administration on 2/6/25 at 5:26 PM, she stated that her expectation for medication pass was timely and accurately, zero errors, but errors were to be reported immediately. She was made aware of the observe eye drop errors. Stated nursed used the wrong eye drops for Resident #53. The nurse said she made the error because the Surveyor makde her extremely nerve. She stated that the adverse effect of residents receiving the wrong medications can be different for each resident, dependent upon their diagnosis. Resident #53 had no adverse effects, checked with MD, no issue with the medication resident received. No issues post either. Staff has been in-served on policy for medication pass, and answered her questions. Requested for medication skilled check for MA A and MA D from DON but was not provided before exit. Record review of facility-provided policy titled Administering Medications, Revised dated 11/25/2017, revealed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. . 7. The individual administering the medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation and interview the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for and 1 (shared medication cart between Hall 100 and 300) of 4 medication carts reviewed for medication storage. - The facility failed to ensure the back of 100 and 300 hall medication carts did not contain eyedrops and nasal spray that were opened but not labeled with the resident's name and not dated. This failure could place residents at risk of adverse medication reactions and infections. Findings Include: During observation on 02/05/25 at 9:49 AM, the following medications were found in the medication carts for back of 100 and 300 hall with MA A: 1. Timolol ophthalmic solution USP 0.5% eyedrop open not dated 2. Dorzol/Timolol solution - eyedrop open and not dated 3. Brimonidine Solution 0.2 % eyedrop open and not dated 4. Fluticasone USP 50 mcg nasal spray open and not dated 5. Fluticasone USP 50 mcg nasal spray open and not dated 6. Fluticasone USP 50 mcg nasal spray open and not dated Interview with MA D on 2/5/25 at 10:00 Am, regarding above medication open and not dated, MA D said eyedrops and nasal spray should be dated when open to alert the nurse about how long it is good for 30 days. MA D said the MA's where responsible to date nasal spray and eyedrops when open Interview with DON on 2/5/25 at 5:15PM regarding the medication open not dated she said it should be dated when open for it effectiveness and when open it's should be good for 30 days . Requested for medication labels policy on 2/5/25 at 5:15 PM, 2/6/25 at 9:50 AM, 2:00 PM and at 4:30PM from DON and the Administrator, none provided before exit. According to the United [NAME] health trust, recommendations were that drops and ointments are used within one month (https://www.ghc.nhs.uk/wp-content/uploads/CHST-Expiry-Dates-of-Medication.pdf).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices for 1 of 6 residents (Resident #55) reviewed for resident assessments. -RN A failed to document pain level for Resident #55 on 1/30/2025 during the 2pm to 10pm shift. -Resident #55 was observed with a skin tear on 02/04/2025 that was not documented in her medical records. -Resident #55's Physician Orders for Calcium + Vitamin D (Calcium = used to help build and maintain bones and teeth. Vitamin D (Cholecalciferol = used for vitamin D deficiency = also used with calcium to maintain bone strength) did not match with their MAR when MA A failed to administer this medication according to Physician Orders. This failure could lead to a resident's decline in health due to incomplete reflection of a resident's current condition and failure to act on potential changes in condition. Findings included: Record review of Resident #55's face sheet last captured on 2/6/25 revealed an [AGE] year-old female originally admitted on [DATE]. Her medical diagnoses included Parkinson's Disease (a degenerative neurological disease causing loss of motor function control), osteoarthritis (inflammation and pain at joints), hypertension (high blood pressure), vertigo (dizziness), intervertebral disc degeneration lumbar region (lower spine bone loss), muscle weakness, and general pain. Record review of Resident #55's Comprehensive MDS (a resident assessment tool) dated 11/13/2024 revealed a BIMS (Brief Interview for Mental Status) score of 15, meaning she was cognitively intact. Resident #55 was usually able to make herself understood and usually understood others. Resident #55 was documented having a wheelchair. She required some supervision with toileting and upper body dressing and partial assistance with transferring from the chair to bed and bed to chair and going to the toilet. Record review of Resident #55's care plan last reviewed 11/26/2024 revealed on 11/10/23 she had an initiated focus area for being at risk for falls related to vertigo, muscle weakness and muscle spasms, with interventions including educating resident on using call light for assistance with ADLs and transfers and being monitored frequently for unspoken needs. Record review of Resident #55's progress notes revealed no documentation regarding her bruising or skin tear. Record review of Resident #55's weekly/monthly skin evaluation completed on 1/12/2025 revealed no skin concerns and no pain. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #55's Physician Orders revealed she had pain evaluation every shift with a start date of 11/09/2023. Record review of Resident #55's TAR (Treatment Administration Record) for January 2025 revealed she was not assessed for pain levels during the evening shift on 1/30/2025, when she allegedly was scratched. There were no other concerns related to pain for the month. Observation and interview with Resident #55 on 2/4/25 at 09:38am, Resident #55 said she was doing well and that staff treat her well. She was observed having a reddish bruise with purple outline on her left outer forearm shaped like a half-moon and had two white strips taped over another part of the bruise with a short black line drawn connecting both strips. It appeared to be healing. She denied pain from the bruise. Resident #55 said she got the injury when a CNA was helping her from her wheelchair to the bed. The CNA told Resident #55 to hug her to help with the transfer and when Resident #55 reached for the aide, the aide's nails scratched her arm. Resident #55 said this incident happened the previous week on 01/30/2025. She said she was not complaining and did not want to disclose the CNA's name. She said no one had done any treatment on the injury since it was bandaged that night. A later observation and interview on 2/6/25 at 10:50am, she said that staff told her the two strips would fall out on its own, and she said she got the injury due to staff taking her to the restroom at night and it must've been the staff member's jewelry or nails that scratched her. Interview with LVN B on 2/6/25 at 11:43am, she said she was the treatment nurse as well. LVN A said head-to-toe skin assessments are done after incidents, monthly as scheduled, or if residents are triggered for pressure sources. LVN A was not aware of Resident #55's skin tear and said she would look at it. LVN A said CNAs have shower sheets and if they notice anything they'll add it on there and that would be reviewed by the DON and treatment nurse. Interview with CNA A on 2/6/25 at 1:43pm, she said she worked with Resident #55 on 2/6/25 and said she saw the two strips on her left arm but could not remember when she noticed it. She denied doing any documentation on Resident #55 as she was not under CNA A's direct care that day. Attempted interview with CNA C on 2/6/25, she documented on 2/2/25 at 12:21am that Resident #55 had no skin issues. The phone number did not have voicemail capabilities and the phone call was not returned. Interview with CNA D on 2/6/25 at 12:23pm, she documented on 1/31/25 at 9:59pm that Resident #55 had no skin issues. CNA D said Resident #55 had no changes in condition that she was aware of. She said she saw Resident #55's skin tear after she returned to work. CNA D asked Resident #55 told her someone took her to the restroom and accidentally scratched her. CNA D said she did not ask for further details, but that Resident #55 was in her right mind and could tell who did it. CNA D documented she had no skin issues because Resident #55 already brought up her skin tear to someone else. Interview with RN A on 2/6/25 at 12:01pm, she was the evening shift nurse on 01/30/2025 for Resident #55's hall. She stated that she documented pain for Resident #55 on PCC (Point Click Care, a medical records system) and that when staff ask Resident #55 how she is doing she always said she was fine. RN A said that if pain levels are not documented, the pain could increase for a resident and staff would not be aware about the pain in order to treat it. RN A was not aware of Resident #55's skin tear and that Resident #55 did not talk to her about it. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MA A on 02/06/2025 at 12:16 p.m., she was the medication aide on 01/30/2025 for evening shift. MA A denied seeing any bruising or injuries on Resident #55 and that if she saw anything she would've reported it. Interview with CNA B on0 2/06/2025 at 01:51 p.m., she was the evening and night aide on 01/30/2025 for Resident #55's hall. She said she did not notice any bruising or skin tears on Resident #55 that night. She said Resident #55 could vocalize her needs. Interview with LVN A on 02/06/2025 at 2:30 p.m., she was the night shift nurse on 1/30/2025 for Resident #55's hall. She said that she was not aware of Resident #55's skin tear. Interview with the DON on 02/06/2025 at 12:29 p.m. he said that he first heard of the skin tear on 2/6/25. In a later interview on 2/6/25 at 3:19pm, he said a risk to residents from not recognizing and documenting a skin tear would be an infection could happen later on, and that pain assessments, including vitals and non-verbal signs of pain should be observed and done so that pain can be addressed in that moment. The DON said missing pain assessments should not happen and that staff have 24 hours to chart if they are aware of anything. Interview with the Administrator on 02/06/2025 at 11:30 a.m., the facility did not have a policy on skin assessments. At a later interview on 4:49pm, she said that if Resident #55 was scratched by staff, it should be reported so the wound care nurse could treat it and see if the facility needed to do any further action on it. The Administrator said that changes in condition should be reported to the charge nurse, and that a risk of not reporting would be a resident's decline. Record review of Resident #63's face sheet dated 2/4/25 revealed a [AGE] year-old female with an admitted [DATE]. Resident #63 had diagnoses which included: venous insufficiency (chronic peripheral = occurs when leg veins do not allow blood to flow back up to your heart), cystitis without hematuria (inflammation of the bladder without blood in the urine), gastro-esophageal reflux disease without esophagitis (back flow of stomach content or heartburn). Record review of Resident #63's quarterly MDS dated ,d+[DATE]//25 revealed a BIMS of 08, which indicated the resident was moderately impaired cognitively. Record review of Resident #63's current physicians orders revealed an order with a start date of 1/1/25, for Calcium 600 mg +Vitamin D10 mcg, 1 tablet by mouth one time per day for anemia at 08:00 AM. Record review of Resident #63's medication administration record (MAR) dated 1/1/25 reflected Calcium 600 mg +Vitamin D3.125mg, 1 tablet by mouth one time per day for supplement at 08:00 AM. MA A initialed as given on 2/4//25. During a medication administration observation on 2/4/25 at 8:20 AM for Resident #63, MA A dispensed one Calcium 600 mg +Vitamin D10 mcg 1 tablet into a medication cup and administered the medication to Resident #63 by mouth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676229	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trucare Living Centers-Columbus	1511 Montezuma Street Columbus, TX 78934

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/25 at 4:21 PM, the DON said he expected the medications to be given as ordered. He said the resident could suffer decline or adverse side effects. He expected both the medication aides to give the medications as ordered. He said the medication aide should have notified the DON about the Calcium 600mg + D3.125mg not available in house and he would have reached out to the doctor about Calcium 600mg + D3.125mg order. He would have to in-service MA's. DON was asked what would happen when rights dose of medication not given , DON said if the right dose of medication was not given, Residents would not receive the right strength of the medication for its effectiveness He said the pharmacist observed MA's with medication administration last month and sometimes the cooperate nurse does. DON was asked for the in-services the pharmacist and the corporate nurse did for medication aide but was not provided before exit. During an interview on 2/6/25 at 5:10 PM, the Administrator said she expected the staff to administer the medications per the physician's order. She said she expected the medication aide to notify the nurse and medication aides so that the doctor can get the medication that appropriate form. She said she expected the correct medication to be given. She said the resident could suffer harm as a result of errors in medication administration. Interview with the Administrator on 2/6/25 at 5:26 PM, she stated that her expectation for medication pass was timely and accurately, zero errors, but errors were to be reported immediately. She was made aware of the observe eye drop errors. Stated nursed used the wrong eye drops for Resident #53. The nurse said she made the error because the Surveyor makde her extremely nerve. She stated that the adverse effect of residents receiving the wrong medications can be different for each resident, dependent upon their diagnosis. Resident #53 had no adverse effects, checked with MD, no issue with the medication resident received. No issues post either. Staff has been in-served on policy for medication pass, and answered her questions. Requested for medication skilled check for MA A and MA D from DON but was not provided before exit. Record review of the facility's Charting and Documentation policy statement last revised 03/01/2022 read in part, All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical records. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care, which included objective observations, treatments or services performed, and changes in the resident's condition and events. Record review of facility-provided policy titled Administering Medications, Revised dated 11/25/2017, revealed: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. (continued on next page)

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	676229	A. Building B. Wing	02/06/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. 7. The individual administering the medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.