STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676237	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Belmont at Twin Creeks	999 Raintree Circle Allen, TX 75013

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from chemical restraints that were not required to treat the residents' medical symptoms for 1 (Resident #89) of 5 residents reviewed for unnecessary medications. The facility failed to ensure Resident #89's PRN prescription of Xanax 0.5mg (a medication used to treat the symptoms of anxiety) was discontinued after 14 days. The facility did not document a rationale for the continued provision of the medication. This failure could place residents at risk for adverse reactions and negative side effects from the administration of medication and dependence on unnecessary medications. Findings included: Review of Resident #89's Face Sheet, dated 05/21/25, reflected he was a [AGE] year-old male, who admitted to the facility on [DATE], with diagnoses including nontraumatic intracerebral hemorrhage (bleeding within the brain tissue itself, not due to a head injury), quadriplegia (the paralysis of both arms and legs, and often the torso, resulting from damage to the cervical (neck) portion of the spinal cord), and restlessness and agitation (a general feeling of unease, nervousness, and difficulty remaining still). Review of Resident #89's MDS Assessment, dated 05/02/25, reflected he was taking a prescribed antianxiety medication which had an indication for use. Review of Resident #89's Care Plan, dated 05/19/25, reflected he was taking a prescribed antianxiety medication (Xanax) due to anxiety disorder. Goals included for Resident #93 to be free from discomfort or adverse reactions related to antianxiety therapy. Review of Resident #89's Physician's Orders, dated 05/21/25, reflected he was prescribed Xanax Oral Tablet 0.5mg (Alprazolam). The orders specified for staff to give 1 tablet via g-tube every 8 hours as needed for anxiety. The start date was 04/26/25. There was no specified end date. Review of Resident #89's Medication Administration Record, from April 2025 to May 2025, reflected Resident #89 received his prescription of Xanax Oral Tablet 0.5mg (Alprazolam) on 04/29/25, 05/01/25, 05/08/25, 05/11/25, and 05/14/25. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on 05/21/25 at 1:00PM, she stated the expectation for PRN psychotropic medications was for the medication not to be prescribed for more than 14 days. She stated she was not sure why Resident #89's PRN prescription medication of Xanax Oral Tablet 0.5mg (Alprazolam) had been prescribed for more than 14 days. She stated she did not know what type of risk this could pose to the resident. A policy related to PRN antianxiety/psychotropic medication use was requested on 05/21/25 at 1:11PM. The Administrator stated the facility did not have a written policy related to this area, but the facility was expected to go by State guidelines.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a discharge summary that included but was not limited to, (i) A recapitulation of the resident's stay that includes, but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results; (ii) A final summary of the resident's status; (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter) for 1 of (Resident #71) of 3 residents reviewed for discharge planning. The facility failed to complete a recapitulation of stay for Resident #71, who discharged to another facility on 05/06/25. This failure could place residents at risk of a recapitulation of their stay being unavailable to help ensure continuity of care once they discharged from the facility. Findings included: Review of Resident #71's Face Sheet, dated 05/21/25, reflected she was an [AGE] year-old female, who admitted to the facility on [DATE], with diagnoses including urinary tract infection (an infection in any part of the urinary system), type 2 diabetes mellitus with hyperglycemia (a chronic condition that happens when you have persistently high blood sugar levels), and unspecified injury of head (a head injury where the specific type or severity of the injury is not clearly defined or known). Resident #71 discharged from the facility on 05/06/25. Review of Resident #71's Recapitulation of Stay, dated 05/07/25, reflected the document was not completed nor signed. The areas of Social Services, Nursing Services, Activities, Dietary Services, and Rehabilitation Services were all missing required information. During an interview with the Director of Nursing on 05/21/25 at 1:00PM, she stated it was expected for each department to complete their appropriate section of a resident's Recapitulation of Stay. She stated she was not sure why Resident #71's Recapitulation of Stay had not been completed. She stated she did not believe a risk was posed to a resident if/when their Recapitulation of Stay was not completed, as the facility still sent all medical paperwork with the resident and/or to the receiving facility upon discharge. A policy related to the completion of recapitulation of stays was requested on 05/21/25 at 1:11PM. The Administrator stated the facility did not have a written policy related to this area, but the facility was expected to go by State guidelines.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure they offered a therapeutic diet when there was a nutritional problem and the health care provider ordered a therapeutic diet for 1 of 3 residents (Resident #27) reviewed for nutritional status. The facility failed to ensure Resident #27 received the therapeutic diet that was ordered for her during the lunch hour on 05/20/25. This failure could result in residents not receiving their ordered therapeutic meal which could lead to malnutrition and/or choking. The findings included: Record review of Resident #27's admission MDS assessment dated [DATE], revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Her BIMs score was 7 indicating she was cognitively impaired. Her diagnoses included stroke, diabetes, non-Alzheimer's disease, and malnutrition. The resident required supervision while eating. The resident was on a therapeutic diet. Record review of Resident #27's Physician Order Summary report reflected: 04/14/25 Regular diet, ground texture, regular/thin consistency. 02/04/25 Magic Cup (supplement) two times a day for malnutrition. Record review of Resident #27's Care Plan reflected: Date initiated: 03/19/25 with revision on: 04/09/25. The resident had a swallowing problem. Facility interventions included: All staff to be informed of resident's special dietary and safety needs. Instruct resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. Keep head of bed elevated 45 degrees during meal and thirty minutes afterwards. Resident to eat only with supervision. Record review of Resident #27's Hospice Note, dated 03/18/25, reflected: RN Comprehensive Visit Mechanical diet (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistance required with meals Notes: Pt [patient] tolerating mechanical soft. Pt continues to refused to eat, consuming mostly fluids . An observation on 05/20/25 at 1:18 PM of Resident #27 revealed the resident was lying in bed at a 30-degree angle. Her tray was raised up and to the right of the resident. The resident could not reach all the food on the tray. The resident was trying to feed herself a magic cup and drink milk. The resident was served a whole ham or turkey sliced sandwich with a slice of tomato on it. The tray also had broccoli florets and macaroni. The Surveyor stepped into the hall and requested staff to assist the resident to sit-up and have access to her tray. An interview and observation with LVN I on 05/20/25 at approximately 1:22 PM she said she did not know how Resident #27 was supposed to eat with her tray far away from her. LVN I said she would get assistance to pull her up. LVN J entered the room with LVN I. Both nurses washed their hands and pulled the resident up in bed. LVN I said the resident was supposed to have assistance to eat, but said the resident would not let staff feed her, because she liked to feed herself. LVN I said she thought the resident was on a regular diet but would check. LVN I left the room and ADON F entered the room. ADON F said the resident was ordered to be on a regular, ground diet and that she was not supposed to be served a whole sandwich. ADON F said the resident was at risk for choking. An interview on 05/20/25 at 2:21 PM with CNA G revealed she delivered the wrong tray to Resident #27 on 05/20/25. She said she did not check the tray and just looked at the tray card for the name. CNA G said she was supposed to check the tray, sit up the resident, make sure the food was the right portion, and ask the resident if she needed anything else. CNA G said she did not check the tray for Resident #27 on 05/20/25 because she was rushing to help. CNA G said the resident was at risk of choking if she was not assisted to sit up and was at risk of having an allergy if she received the wrong diet tray. CNA G said sometimes the resident received a puree' diet and sometimes she received a regular diet . An interview on 05/20/25 at 2:26 PM with the Dietician for Resident #27 revealed the resident was supposed to be on a ground diet. The Dietician said the macaroni and cheese was the proper texture and the broccoli was the appropriate texture. The Dietician said the staff returned Resident 27's whole sandwich and the resident received a tuna fish sandwich instead. The Dietician said the resident did not have any choking incidents. The Dietician she was on a ground diet to optimize her oral intake. The Dietician said she did not know if the resident had dysphagia but had a care plan for trouble swallowing. The Dietician said the kitchen staff and nursing staff were responsible for checking the resident's tray. An interview on 05/20/25 at 3:07 PM with the DON revealed she did not know what happened with Resident #27's tray. She said dietary and nursing were responsible for checking the trays. The DON said she was told the resident was delivered a thinly sliced turkey sandwich. The DON said she did not know why the resident did not have supervision to eat and staff were supposed to make sure that she was in the right position to eat. The DON said the resident was at risk for choking if she was served the wrong diet. Record review of the facility policy, Regular Ground Diet, dated 07/26/22, reflected: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy It is the policy of this facility that the Dining Services Department shall provide a Regular Ground diet when ordered by a physician that is nutritionally adequate and texturally appropriate for the Patient. Responsibility: All Dining Services Staff Procedure: 1. All Dining Services staff must follow the Regular Ground Diet as written on the modified diet spreadsheets. 2. The Regular Ground Diet shall be served according to the guidelines listed in the Diet Rationale from the menu company, unless otherwise indicated. 3. All meats must be ground on all meal trays. 4. Any Patients requiring a different meat texture modification shall have a different diet order indicating that difference. For example, Patients able to tolerate a whole piece of bacon may obtain a physician order; May have a whole piece of bacon. 5. The Dining Services Director and/or designee shall interview the Patient upon admission, readmission and as needed to determine the tolerance of certain foods allowed on the Regular Ground Diet. Any intolerances shall be listed on the tray ticket system. 6. Patients with several food intolerances may be referred to Speech Therapy for a screen.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #73) of four residents reviewed for pharmacy services. The facility failed to ensure the medication cart contained accurate narcotic logs for Resident #73. This failure could place residents at risk for medication error and drug diversion. Findings included: Record review of Resident #73's admission MDS assessment, dated 05/01/25, reflected Resident #73 was a [AGE] year-old male. He admitted to the facility on [DATE] with diagnoses including cancer, bone fracture, and Parkinson's disease. Resident #73 had a BIMs score of 14 which indicated he was cognitively intact. Record review of Resident #73's care plan, dated 04/24/25, revealed the resident was on pain medication therapy (morphine) for fracture related to bone cancer. Facility interventions included: Administer pain medications as ordered by physician. Record review of Resident #73's physician order summary, dated May 2025 reflected: 05/13/25 Morphine 15 milligrams, give half a tablet, by mouth three times a day for pain. 04/24/25 Morphine 15 milligrams, give half a tablet, by mouth every 4 hours as needed for pain. Record review of Resident #73's May 2025 Medication Administration Record reflected: 1. Morphine 15 milligrams, (half a tablet) was administered to the resident once on 05/13/25 at 9:00 PM, two times on 05/14/25 at 3:00 PM and 9:00 PM, and three times a day from 05/15/25 - 05/19/25 at 9:00 AM, 3:00 PM, and 9:00 PM, and one time on 05/20/25 at 9:00 AM. 2. Morphine 15 milligrams, (half a tablet) PRN (as needed order) was administered to the resident once on 05/14/25 at 4:00 AM. The total doses documented as administered was 19. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #73's Narcotic Record reflected the resident was ordered to receive Morphine 15 milligrams three times a day. The resident received the following doses of Morphine: 15 milligrams on 05/13/25 at 9:00 AM 7.5 milligrams on 05/14/25 at 12:00 AM and 9:00 PM 7.5 milligrams on 05/15/25 at 12:30 PM and 9:00 PM 7.5 milligrams on 05/16/25 at 9:30 AM and 9:00 PM 7.5 milligrams on 05/17/25 at 04:33 AM, 7:00 AM, and 9:00 PM 7.5 milligrams on 05/18/25 at 7:00 AM and 9:00 AM 7.5 milligrams on 05/19/25 at 9:00 AM, 11:22 AM, 1:00 PM, and 9:00 PM 7.5 milligrams on 05/20/25 at 9:00 AM The total doses signed out as administered was 17. Review of Resident #73's Morphine card that contained the morphine pills reflected the count was correct. Record reviews of the MAs competency checks reflected: MA E - competency check completed on 01/08/24 and signed by ADON F. MA D - competency check completed on 02/25/21 and signed by ADON F. MA C - competency check completed on 01/08/25 and signed by ADON F. An interview and observation on 05/21/25 at 2:48 PM revealed Resident #73 was lying in bed. The resident said he was not aware that he missed 2 doses of Morphine between 05/13/25 - 05/20/25. He said it did not affect his pain level. The resident said his current pain level was a 6 on a [NAME] of 1-10 and was told that he was about to receive a dose of Morphine. An interview on 05/21/25 at 12:26 PM with LVN A revealed she completed a narcotic count of Resident #73's Morphine. LVN A said the Morphine Card showed the resident was supposed to receive Morphine 15 milligrams three times a day. The Narcotic Count Sheet reflected the same dose. LVN A said prior to 05/13/25, the resident was ordered to receive 15 milligrams of Morphine three times a day. LVN A said the order was changed to 7.5 milligrams three times a day on 05/13/25. LVN A said the nurse would cut the dose in half and destroy it with the MA as a witness. An interview on 05/21/25 at approximately 12:40 PM with ADON B revealed there were missing signatures from the narcotic record indicating there was not a witness to the half tab (7.5 milligrams) being wasted. ADON B said she did not know why there were missing signatures on the narcotic record. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/22/25 at 11:18 AM with MA C revealed she worked the 6:00 AM - 2:00 PM shift with Resident #73. She said she administered a 7.5 milligram of dose to the resident at 12:30 PM on 05/15/25 instead of 9:00 AM because he did not want the dose at 9:00 AM. She said she documented in the medication administration record that she administered the dose at 9:00 AM even though she did not. She said if a dose was not given, then she was supposed to notify the nurse and document the dose as not given. An interview on 05/22/25 at 12:51 PM with MA D revealed he worked double shifts on the weekend on 05/17/25 and 05/18/25. He said he documented on the medication administration record that he gave the doses at 9:00 AM, 3:00 PM, and 9:00 PM on those days. On the narcotic record he administered a dose at 7:00 AM and 9:00 PM on 05/17/25 and 7:00 AM and 9:00 AM on 05/18/25. He said he did not know why the narcotic record and the medication administration record showed different times, but that he gave all the doses as ordered on 05/17/25 and 05/18/25. He said he saved the half table of Morphine 7.5 milligrams and left the doses in a cup in the medication cart. He said the risk to the resident was a tough question because he gave all the doses. An observation and interview on 05/21/25 at 3:23 PM revealed MA D wasted 7.5 milligrams of morphine with unknown nurse in the drug buster in the cart. MA D then administered 7.5 milligrams of Morphine to Resident #73. MA D said she worked the 2:00 PM-10:00 pm shift on 05/13/25 - 05/16/25 and 05/19/25. She said that on those days she did not administer the 3:00 PM doses of Morphine because the resident told her he already received it. The Narcotic Record reflected the 3:00 PM doses were not administered on 05/13/25 - 05/16/25. MA D said she thought that maybe the nurse had already administered the dose, so she just documented on the medication administration record that she administered the dose. She said the risk to the resident was overdose. A follow-up interview on 05/21/25 at 1:38 PM with ADON B for Resident #73 revealed the half tab (7.5 milligrams) of Morphine was being saved. ADON B said she found out the MAs and nurses were saving the half tab on 05/19/25. She said she instructed the staff that the half tab had to be destroyed with a witness on 05/19/25. ADON B said the facility could not change the narcotic record and Morphine card to the correct dose of 7.5 milligrams, but that a correction sticker could have been placed on the record and card. ADON B said the nurse did not do that. ADON B said they could not send the morphine pills back to the pharmacy and they were supposed to be destroyed. ADON B said she told staff to call on 05/19/25 to get the correct dose card and correct narcotic record. ADON B said she did not know why staff had documented that they gave doses on the Medication Administration Record that were not actually given. ADON B said the MA was administering the scheduled doses and the nurse was supposed to waste the other half dose that was left over. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 05/21/25 at 2:08 PM, 05/22/25 at 12:48 PM, and 05/22/25 2:10 PM with the DON for Resident #73 revealed 2 staff were supposed to witness a drug's destruction. The dose was to be placed in the Drug Buster that was kept on the medication cart. The DON said she found out on 05/19/25 that the staff had been saving the half tab and not destroying it. The DON said staff should have contacted the doctor and the pharmacy to get the correct dose on the Morphine card and narcotic record. The DON said she spoke to LVN A and was told the doctor said it was ok to use the Morphine 15 milligrams and split the tablets in half. The DON said Resident #73 was scheduled to receive Morphine 7.5 milligrams three times a day. The DON said she did not know staff were signing in the Medication Administration Record that they were administering doses that they did not administer. The DON said to ensure the MAs were competent, the facility did competency checks, and the pharmacy consultant would pick someone to watch monthly to do medication pass. She said the MAs were not trained at the facility, but they were trained and had a certification. The facility said they did competency checks before they were assigned to pass medications. The DON said the MAs worked under the nurse's license, the DON's license, and the Administrator's license. She said the resident was at risk of pain and not receiving the correct dose due to not receiving the doses of Morphine. Record review of the facility policy titled Pharmacy Services Overview, revised April 2019, reflected: 1. Pharmaceutical services consists of: a. the processes of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding (e.g., intravenous antibiotics), dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and/or disposing of all medications, biologicals, chemicals; b. the provision of medication-related information to health care professionals and residents; c. the process of identifying, evaluating and addressing medication-related issues including the prevention and reporting of medication errors; and d. the provision, monitoring and/or the use of medication-related devices . Record review of the facility policy titled Management of Controlled Medications, dated January 2024, reflected: POLICY The Facility staff will follow the method of accounting for controlled medications through receiving, administration, storage, and destruction, which meets the requirements of state and federal narcotic enforcement agencies. PROCEDURE Receipt from Pharmacy (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Upon receipt of a controlled medication, the charge nurse will verify/initial the receipt of and validate the quantity received with a second nurse/courier using the Controlled Drug Receipt/Record/Disposition Form. 2. Upon receipt, controlled medications will be logged on a Controlled Drug Receipt/Record/Disposition Form if the form did not come from pharmacy. 3. Controlled medications will immediately be placed under double lock, in the appropriate medication cart. Shift-to-Shift Count: 1. Controlled medications will be counted every shift change (scheduled or incidental) by an authorized staff member (RN/LVN/CMA) reporting on duty with an authorized staff member reporting off duty. a. Scheduled shift change = routine shift changes (8, 12, or 16 hours) b. Incidental shift change = interrupted routine shift due to any circumstances (staff illness, reassignments, partial shift work etc) 2. At the end of every shift the authorized staff member reporting on duty and the authorized staff member reporting off duty meet at the designated medication cart or storage area to count controlled medications. 3. The authorized staff member reporting off duty reads all Controlled Drug Receipt/Record/Disposition Form one sheet at a time, announcing the Patient's name, the medication, and dose. 4. The authorized staff member reporting on duty counts the amount of remaining controlled medications (bubble pack or bottle) and announces the number out loud. 5. Steps 3 and 4 are repeated for each controlled medication and/or Controlled Drug Receipt/Record/Disposition Form. 6. Both the authorized staff member reporting off duty and the authorized staff member reporting on duty verify that the count of all controlled medications and Controlled Drug Receipt/Record/Disposition Form(s) are correct and sign the Controlled Medication Count Sheet. 7. In counting controlled medications, the authorized staff member reporting on duty is alert for any evidence of a substitution. a. Inspect tablets and solutions closely. Note any defects in medication container. b. Immediately report any suspicion of substitution or tampering with controlled medications to the Director of Nursing. Generate the appropriate incident reports. (continued on next page)

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The Belmont at Twin Creeks	999 Raintree Circle Allen, TX 75013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. If a controlled medication is discontinued or the Patient expires, the controlled medication must remain in the scheduled and/or incidental count until the Director of Nursing (DON) picks up the controlled medication for destruction. When picking up the controlled medication the DON and authorized staff member in control of the keys will both sign and date below the number of controlled medications remaining on each Controlled Drug Receipt/Record/Disposition Form. 8. The DON will log the discontinued controlled medications on the Destruction Log and place them under double lock in the designated controlled medication destruction bin until the pharmacist returns for drug destruction. 9. During the drug destruction, all narcotics will be removed from their container, placed in the biohazard bag/box and destroyed by applying liquids over them. If a discrepancy is found: a. Check the Patient's order sheets, administration records and nurse's notes in the chart to see if a controlled medication has been administered and not recorded. b. Check previous recordings on the Controlled Drug Receipt/Record/ Disposition Form for mistakes in arithmetic or error in transferring numbers from one sheet to the next. c. If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the Director of Nursing/designee IMMEDIATELY. d. The authorized staff member reporting off duty must remain in the Facility during the investigation. e. Generate the appropriate incident statements. f. The Director of Nursing/designee will then contact the Administrator. The Administrator will determine if the incident is reportable (internal/external). The Consultant Pharmacist will be notified .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors for one (Resident #73) of four residents reviewed for medication errors. The facility failed to ensure morphine (pain medicine) was administered to Resident #73 as ordered from 05/11/25 until 05/18/25 and 05/20/25. (9 days). This failure could place residents at risk for not receiving medications as ordered by their physician and not receiving the intended therapeutic benefit of the medications. Findings included: Record review of Resident #73's admission MDS assessment dated [DATE] reflected Resident #73 was a [AGE] year-old male. He admitted to the facility on [DATE] with diagnoses including cancer, bone fracture, and Parkinson's disease. Resident #73 had a BIMs score of 14 which indicated he was cognitively intact. Record review of Resident #73's care plan, dated 04/24/25, revealed the resident was on pain medication therapy (morphine) for fracture related to bone cancer. Facility interventions included: Administer pain medications as ordered by physician. Record review of Resident #73's physician order summary, dated May 2025 reflected: 05/13/25 Morphine 15 milligrams, give half a tablet by mouth three times a day for pain. 04/24/25 Morphine 15 milligrams, give half a tablet by mouth every 4 hours as needed for pain. Record review of Resident #73's May 2025 Medication Administration Record reflected: 1. Morphine 15 milligrams, (half a tablet) was administered to the resident once on 05/13/25 at 9:00 PM, two times on 05/14/25 at 3:00 PM and 9:00 PM, and three times a day from 05/15/25 - 05/19/25 at 9:00 AM, 3:00 PM, and 9:00 PM, and one time on 05/20/25 at 9:00 AM. 2. Morphine 15 milligrams, (half a tablet) PRN (as needed order) was administered to the resident once on 05/14/25 at 4:00 AM. The total doses documented as administered was 19. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #73's Narcotic Record reflected the resident was ordered to receive Morphine 15 milligrams three times a day. The resident received the following doses of Morphine: 15 milligrams on 05/13/25 at 9:00 AM 7.5 milligrams on 05/14/25 at 12:00 AM and 9:00 PM 7.5 milligrams on 05/15/25 at 12:30 PM and 9:00 PM 7.5 milligrams on 05/16/25 at 9:30 AM and 9:00 PM 7.5 milligrams on 05/17/25 at 04:33 AM, 7:00 AM, and 9:00 PM 7.5 milligrams on 05/18/25 at 7:00 AM and 9:00 AM 7.5 milligrams on 05/19/25 at 9:00 AM, 11:22 AM, 1:00 PM, and 9:00 PM 7.5 milligrams on 05/20/25 at 9:00 AM The total doses signed out as administered was 17. Review of Resident #73's Morphine card that contained the morphine pills reflected the count was correct. An interview on 05/21/25 at 2:48 PM revealed Resident #73 was lying in bed. The resident said he was not aware that he missed 2 doses of Morphine between 05/13/25 - 05/20/25. He said it did not affect his pain level. The resident said his current pain level was a 6 on a [NAME] of 1-10 and was told that he was about to receive a dose of Morphine. An interview on 05/21/25 at 12:26 PM with LVN A revealed she completed a narcotic count of Resident #73's Morphine. LVN A said the Morphine Card showed the resident was supposed to receive Morphine 15 milligrams three times a day. The Narcotic Count Sheet reflected the same dose. LVN A said prior to 05/13/25, the resident was ordered to receive 15 milligrams of Morphine three times a day. LVN A said the order was changed to 7.5 milligrams three times a day. LVN A said the nurse would cut the dose in half and destroy it with the MA as a witness. An interview on 05/21/25 at approximately 12:40 PM with ADON B revealed there were missing signatures from the narcotic record indicating there was not a witness to the half tab (7.5 milligrams) being wasted. ADON B said she did not know why there were missing signatures on the narcotic record. An interview on 05/22/25 at 11:18 AM with MA C revealed she worked the 6:00 AM - 2:00 PM shift with Resident #73. She said she administered a 7.5 milligram of dose to the resident at 12:30 PM on 05/15/25 instead of 9:00 AM because he did not want the dose at 9:00 AM. She said she documented in the medication administration record that she administered the dose at 9:00 AM even though she did not. She said if a dose was not given, then she was supposed to notify the nurse and document the dose as not given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/22/25 at 12:51 PM with MA D revealed he worked double shifts on the weekend on 05/17/25 and 05/18/25. He said he documented on the medication administration record that he gave the doses at 9:00 AM, 3:00 PM, and 9:00 PM on those days but on the narcotic record he only administered a dose at 7:00 AM and 9:00 PM on 05/17/25 and 7:00 AM and 9:00 AM on 05/18/25. He said he did not know why the narcotic record and the medication administration record showed different times, but that he gave all the doses as ordered on 05/17/25 and 05/18/25. He said he saved the half table of Morphine 7.5 milligrams and left the doses in a cup in the medication cart. He said the risk to the resident was a tough question because he gave all the doses. An observation and interview on 05/21/25 at 3:23 PM revealed MA D wasted 7.5 milligrams of morphine with unknown nurse in the drug buster in the cart. MA D then administered 7.5 milligrams of Morphine to Resident #73. MA D said she worked the 2:00 PM-10:00 pm shift on 05/13/25 - 05/16/25 and 05/19/25. She said that on those days she did not administer the 3:00 PM doses of Morphine because the resident told her he already received it. The Narcotic Record reflected the 3:00 PM doses were not administered on 05/13/25 - 05/16/25. MA D said she thought that maybe the nurse had already administered the dose, so she just documented on the medication administration record that she administered the dose. She said the risk to the resident was overdose. A follow-up interview on 05/21/25 at 1:38 PM with ADON B for Resident #73 revealed the half tab (7.5 milligrams) of Morphine was being saved. ADON B said she found out the MAs and nurses were saving the half tab on 05/19/25. She said she instructed the staff that the half tab had to be destroyed with a witness on 05/19/25. ADON B said the facility could not change the narcotic record and Morphine card to the correct dose of 7.5 milligrams, but that a correction sticker could have been placed on the record and card. ADON B said the nurse did not do that. ADON B said they could not send the morphine pills back to the pharmacy and they were supposed to be destroyed. ADON B said she told staff to call on 05/19/25 to get the correct dose card and correct narcotic record. ADON B said she did not know why staff had documented that they gave doses on the Medication Administration Record that were not actually given. ADON B said the MA was administering the scheduled doses and the nurse was supposed to waste the other half dose that was left over. An interview on 05/21/25 at 2:08 PM and 05/22/25 at 12:48 PM with the DON for Resident #73 revealed 2 staff were supposed to witness a drug's destruction. The dose was to be placed in the Drug Buster that was kept on the medication cart. The DON said she found out on 05/19/25 that the staff had been saving the half tab and not destroying it. The DON said staff should have contacted the doctor and the pharmacy to get the correct dose on the Morphine card and narcotic record. The DON said she spoke to LVN A and was told the doctor said it was ok to use the Morphine 15 milligrams and split the tablets in half. The DON said Resident #73 was scheduled to receive Morphine 7.5 milligrams three times a day. The DON said she did not know staff were signing in the Medication Administration Record that they were administering doses that they did not administer. She said the resident was at risk of pain and not receiving the correct dose due to not receiving the doses of Morphine. Record review of the facility policy titled Medications, dated November 2017, reflected: Upon admission (including readmission) of each Patient/Resident, the physician's orders for the Patient/Resident must be reviewed and reconciled by the Charge Nurse and the Director of Nursing or his/her designee for accuracy in the Electronic Medical Record . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Management of Controlled Medications, dated January 2024, reflected: POLICY The Facility staff will follow the method of accounting for controlled medications through receiving, administration, storage, and destruction, which meets the requirements of state and federal narcotic enforcement agencies. PROCEDURE Receipt from Pharmacy 1. Upon receipt of a controlled medication, the charge nurse will verify/initial the receipt of and validate the quantity received with a second nurse/courier using the Controlled Drug Receipt/Record/Disposition Form. 2. Upon receipt, controlled medications will be logged on a Controlled Drug Receipt/Record/Disposition Form if the form did not come from pharmacy. 3. Controlled medications will immediately be placed under double lock, in the appropriate medication cart. Shift-to-Shift Count: 1. Controlled medications will be counted every shift change (scheduled or incidental) by an authorized staff member (RN/LVN/CMA) reporting on duty with an authorized staff member reporting off duty. a. Scheduled shift change = routine shift changes (8, 12, or 16 hours) b. Incidental shift change = interrupted routine shift due to any circumstances (staff illness, reassignments, partial shift work etc) 2. At the end of every shift the authorized staff member reporting on duty and the authorized staff member reporting off duty meet at the designated medication cart or storage area to count controlled medications. 3. The authorized staff member reporting off duty reads all Controlled Drug Receipt/Record/Disposition Form one sheet at a time, announcing the Patient's name, the medication, and dose. 4. The authorized staff member reporting on duty counts the amount of remaining controlled medications (bubble pack or bottle) and announces the number out loud. 5. Steps 3 and 4 are repeated for each controlled medication and/or Controlled Drug Receipt/Record/Disposition Form. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Both the authorized staff member reporting off duty and the authorized staff member reporting on duty verify that the count of all controlled medications and Controlled Drug Receipt/Record/Disposition Form(s) are correct and sign the Controlled Medication Count Sheet. 7. In counting controlled medications, the authorized staff member reporting on duty is alert for any evidence of a substitution. a. Inspect tablets and solutions closely. Note any defects in medication container. b. Immediately report any suspicion of substitution or tampering with controlled medications to the Director of Nursing. Generate the appropriate incident reports. c. If a controlled medication is discontinued or the Patient expires, the controlled medication must remain in the scheduled and/or incidental count until the Director of Nursing (DON) picks up the controlled medication for destruction. When picking up the controlled medication the DON and authorized staff member in control of the keys will both sign and date below the number of controlled medications remaining on each Controlled Drug Receipt/Record/Disposition Form. 8. The DON will log the discontinued controlled medications on the Destruction Log and place them under double lock in the designated controlled medication destruction bin until the pharmacist returns for drug destruction. 9. During the drug destruction, all narcotics will be removed from their container, placed in the biohazard bag/box and destroyed by applying liquids over them. If a discrepancy is found: a. Check the Patient's order sheets, administration records and nurse's notes in the chart to see if a controlled medication has been administered and not recorded. b. Check previous recordings on the Controlled Drug Receipt/Record/ Disposition Form for mistakes in arithmetic or error in transferring numbers from one sheet to the next. c. If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the Director of Nursing/designee IMMEDIATELY. d. The authorized staff member reporting off duty must remain in the Facility during the investigation. e. Generate the appropriate incident statements. f. The Director of Nursing/designee will then contact the Administrator. The Administrator will determine if the incident is reportable (internal/external). The Consultant Pharmacist will be notified .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #57 and Resident #84) of eight residents, reviewed for infection control. 1. The facility failed to ensure CNA G performed hand hygiene during incontinence care and did not soil the wipes container with soiled gloves for Resident #57. 2. The facility failed to ensure CNA H did not soil the wipes container with soiled gloves for Resident #84. This failure placed residents at risk for healthcare associated cross contamination and infections. Findings included: 1. Review of Resident 57's Quarterly MDS Assessment, dated 03/28/25, reflected the resident had a BIMs score of 13 and was cognitively intact. She was a [AGE] year-old female admitted to the facility on [DATE]. The resident had diagnoses which included fall with fracture. The resident was occasionally incontinent of bladder and was always incontinent of bowel. The resident required partial assistance with toileting. Review of Resident #57's Comprehensive Care Plan, dated 05/22/25, reflected the resident had an activities of daily living self-care performance deficit. Facility interventions included: Toilet use: The resident requires assistance of one or two staff for toileting. An observation on 05/20/25 at 10:55 AM of Resident #57 revealed CNA G was preparing to perform incontinence Care. CNA G washed her hands, put on gloves, positioned the resident in bed on her back, folded down the brief, and cleaned the vaginal area. The brief was soiled with bowel movement. CNA G turned the resident to her right side and wiped her buttocks. CNA G grabbed clean wipes out of the wipes container with soiled gloves. CNA G changed her gloves but did not perform hand hygiene. CNA G put a clean brief on the resident. An interview on 05/20/25 at 11:12 AM with CNA G revealed she was supposed to perform hand hygiene after removing her soiled gloves. She also said she was not supposed to touch the container of wipes with soiled gloves. CNA G said she did not perform hand hygiene and touched the wipes container with soiled gloves because she was stressed. CNA G said the risk to the resident was infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 84's Quarterly MDS Assessment, dated 04/15/25, reflected the resident had a BIMs score of 6 and was cognitively impaired. She was an [AGE] year-old female admitted to the facility on [DATE]. The resident had diagnoses which included cancer. The resident was always incontinent of bladder and bowel. The resident required partial assistance with toileting. Review of Resident #84's Comprehensive Care Plan, dated 05/04/25, reflected the resident had an activities of daily living self-care performance deficit. Facility interventions included: Toilet use: The resident requires assistance of one or two staff for toileting. An observation on 05/20/25 at 12:25 PM of Resident #84 revealed CNA G and CNA H were preparing to perform incontinence care. Both CNAs washed their hands and put on gloves. The resident was positioned on her back. CNA H folded down the resident's brief and it was soaked with urine. The resident was lying on a dry bed pad, but the resident's bottom sheet had a large urine stain on it. The brief also contained bowel movement. CNA H began cleansing the buttocks and picked up clean wipes with soiled gloves. CNA H placed the soiled wipes container on the bedside table. The CNAs changed their gloves and washed their hands. CNA H put a clean brief on the resident but did not change the soiled sheet. CNA H said she would change the sheet later. An interview on 05/20/25 at 12:30 PM with CNA H revealed she was not supposed to touch and move the wipes container with soiled gloves on the bedside table. She said she was also not supposed to leave soiled linen on the bed. CNA H said she did it this time because she was in a hurry and the risk to the resident was contamination. An interview on 05/21/25 at 4:12 PM with ADON B revealed staff were supposed to change gloves and perform hand hygiene when going from a dirty area to a clean area. ADON B also said it was not ok for staff to stick soiled, gloved, hands into the wipe's container and pull out wipes. ADON B said the risk to the resident was infection. An interview with the DON on 05/22/25 at 12:42 PM revealed staff were supposed to change gloves and perform hand hygiene when going from a dirty area to a clean area. The DON also said it was not ok for staff to stick soiled, gloved, hands into the wipe's container. The DON said the risk to the resident was infection and contamination. Record review of the facility policy, Infection Control, dated November 2017, reflected: 1. The facility must establish an infection prevention and control program (IPCP) that must include: a. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all Patients, staff, volunteers, visitors, and other individuals . Record review of the facility policy, Handwashing, dated August 2012, reflected: GUIDELINES Standards of Practice/Hand washing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hand washing is the single most important means of preventing the spread of infection. The principle of good hand washing is that of using friction to mechanically remove micro-organisms. After Patient contact - Wash hands with soap and running water - Rinse hands with running water - Dry hands well with paper towel - Use paper towel to turn off faucet. All manually controlled faucets are considered contaminated. - Dispose of single use or linen towels in appropriate receptacle. - May use Hand sanitizing gel in place of soap and water.