STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676301	A. Building B. Wing	11/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Winds Living & Rehabilitation	3301 Fm 3009 Schertz, TX 78154

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 1 of 16 residents (Resident #162) who were observed for call light placement. The facility failed to ensure the call light was within reach for Resident #162 on 11/20/24. This failure could affect any resident and keep them from calling for help as needed. The findings were: Record review of Resident #162's Admission MDS assessment, dated 5/10/24, revealed an [AGE] year-old female was admitted on [DATE] with diagnosis of fractures and other multiple trauma, atrial fibrillation (a heart condition that causes the upper chambers of the heart to beat irregularly), heart failure, and renal insufficiency (when the kidneys are not functioning properly). Section O of the MDS showed she received hemodialysis dialysis (treatment that filters waste and extra water from the blood when the kidneys are not functioning properly). The resident's BIMS score was 15, which indicated her cognition was fully intact. Section GG showed she was dependent for transfers, had a wheelchair, and impairment on one side of her body. During an observation and interview on 11/20/24 at 5:15 p.m. Resident #162 was sitting up in a wheelchair by her bedside with a tray table in front of her. The tray table had her untouched dinner on it. Resident #162 was moaning and stated please someone help me I am in so much pain I can not take it anymore. Resident #162's call light was on the side of the dresser on the floor and not in reach. Resident #162 stated the van driver had assisted her to her room in her wheelchair upon return to the facility from dialysis. Resident #162 said the van driver did not give her, her call light and left. Resident #162 said her cushion was causing her excruciating pain after sitting on it all day at dialysis. She stated she was sliding in her chair and was not able to adjust herself. She stated while she was missing one hand, she could press the call light with her other hand if it was in reach. Resident #162's roommate stated staff often does not put her call light in reach and she will push the call light on behalf of Resident #162 so she can get assistance from staff. The roommate then pressed the call light. At 5:18 p.m. CNA E stated the residents call light was not in reach and she did not know who brought the resident to her room. CNA E stated she would get another staff to help her use the Hoyer lift to get the resident in bed. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676301	A. Building B. Wing	11/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Winds Living & Rehabilitation	3301 Fm 3009 Schertz, TX 78154

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 12:12 p.m. the DON stated Resident #162 normally comes back before dinner service however she returned during dinner service that day and the driver assisted the resident to her room. The DON stated the driver cannot transfer the resident to her room but he could and should have put the call light in reach for the resident. The DON stated they only had one working Hoyer lift but planned to have another delivered but it did not affect the timely response for care of the residents. During an interview on 11/21/24 at 5:22 p.m. the Administrator stated Resident #162 had a cell phone she could use to call him if she needed anything. The Administrator stated the call light should be in reach for all residents. Record review of the facility's policy titled Answering the Call light, dated 10/2010, stated The purpose of this procedure is to respond to the resident's request and needs. General guidelines .5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/23/2024
NAME OF PROVIDER OR SUPPLIER: Autumn Winds Living & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3301 Fm 3009 Schertz, TX 78154	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused result in serious bodily injury for 4 of 16 residents (Resident #9, Resident #36, Resident #21, and Resident #40) whose records were reviewed for abuse and neglect: The facility failed to report to the state reporting agency (HHSC) when Resident #9, #21, #36, and #40 tested positive for amphetamines during a facility investigation of possible drug use at the facility. These deficient practices could affect residents by contributing to further abuse and neglect. The findings were: Resident #9 Record review of Resident #9's Admission record revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses of chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe. It's caused by damage to the lungs that reduces airflow.), vascular dementia (a type of dementia that occurs when blood vessels in the brain are damaged, reducing the flow of oxygen and nutrients to the brain), mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, extrapyramidal and movement disorder (are a group of movement disorders that can occur as a side effect of certain drugs, particularly antipsychotics), nicotine dependence (a chronic disease that occurs when the body becomes addicted to nicotine, a stimulant found in tobacco products), schizophrenia (a chronic mental disorder that affects how people think, perceive reality, and interact with others), and insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get quality sleep). Record review of Resident #9's quarterly MDS, dated [DATE], revealed the resident had fully intact cognition for daily decision making. Record review of Resident #9's care plan contained a care area, last edited on 11/20/24, that stated the resident had a history of alcohol or drug abuse as evidenced by recently tested positive with interventions to MD/RP will be notified of any changes in residents behavior / mental state. Also, a care area for Resident #9 smokes cigarettes and he set a fire at the last placement due to hearing what he thought was a gun being loaded. He will have strictly supervised smoking breaks; no lighter will be in his possession with interventions to All smoking materials are kept at the nurse's station between smoke breaks, [Resident #9] will be given two cigarettes a break and offered a light-he will be supervised at all times during the break. Record review of Resident #9's nursing note written by LVN B, dated 11/17/24, stated It had been noted by staff that res had been acting abnormally. This nurse was given an order to test urine for drugs. Urine came up positive for amphetamines . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #36 Record review of Resident #36's Admission record revealed a [AGE] year-old female admitted [DATE] and readmitted [DATE] with diagnosis of schizoaffective disorder (a chronic mental illness that involves symptoms of both schizophrenia and a mood disorder, such as bipolar disorder or depression), bipolar type, unspecified atrial fibrillation (a heart condition that causes the upper chambers of the heart to beat irregularly), unspecified convulsions (nerve cell activity in the brain is disrupted, causing muscles to involuntarily contract and spasm), extrapyramidal and movement disorders (a group of movement disorders that can occur as a side effect of antipsychotic and other drugs), bipolar disorder (a serious mental illness that causes extreme mood swings, along with changes in energy, thinking, behavior, and sleep), unspecified, recurrent depressive disorders, and major depressive disorder (a serious mood disorder that can affect how someone feels, thinks, and acts). Record review of Resident #36's quarterly MDS, dated [DATE], revealed the resident had mild cognitive impairment for daily decision making. Record review of Resident #36's care plan contained a care area, last edited on 11/18/24, that stated the resident had a history of alcohol or drug abuse with interventions to MD/RP will be notified of any changes in residents' behavior / mental state. Also, a care area for potential for safety hazards, injury related to smoking with an intervention to encourage resident to keep all smoking material at nurse's station after smoke break. Record review of Resident #36's nursing note written by LVN G, dated 11/15/24, stated At beginning of this shift, during report, resident observed in wheelchair at nurses' station having erratic behavior and movement. Resident requested to have staff assist her to her room, once in room resident was heard yelling I'm too high, oh God help me. This nurse and day shift nurse assessed resident; resident admitted she had taken a pill that a man had given to her. 911 called. EMS arrived and resident taken to [hospital]. Resident did ask for staff to notify her [family member] before leaving facility. NP/DON/Administrator/Sister notified. Record review of Resident #36's nursing note written by LVN B, dated 11/17/24, stated Res had been sent to hospital for erratic behavior on the 15th. This nurse came to work on the 16th and PA had given orders for urine drug screening. Urine collected and res tested positive for amphetamines . Record review of CNA C's statement dated 11/15/24 on stated I was in the bathroom and heard some people talking and heard a man (Resident #40) asking the lady (Resident #36) in the bathroom which one do you want and I guess she took whatever he gave her. During an interview on 11/21/24 at 2:44 p.m. Resident #36 stated Resident #40 and her snorted white powder off her phone last Friday the 15th of November. Resident #36 stated Residents #9, #21 #40, and #47 would smoke drugs from a pipe on the back patio when staff were not around. Resident #40 Record review of Resident #40's Admission record revealed a [AGE] year-old male admitted [DATE] with diagnoses of chronic obstructive pulmonary disease, disruption of external operation (surgical) wound, acquired absence of right leg below knee, acquired absence of left leg above knee, and depression. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Autumn Winds Living & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3301 Fm 3009 Schertz, TX 78154	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #40's care plan contained a care area, last edited on 11/18/24, that stated the resident had a history of illicit drug use/abuse with interventions to MD/RP will be notified of any changes in resident's behavior/mental state. Also, a care area for potential for safety hazard, injury related to smoking. Resident assessed to be a supervised smoker. Resident smokes traditional cigarettes. Interventions included Encourage resident to keep all smoking material at nurse's station after smoke break. Record review of Resident #40's progress notes, revealed a note dated 11/20/24 for 11/15/24, written by NP F, stated Questionable activities reported that pt may be bringing unknown substance and giving it to other residents, his drug screen is pending . Resident #21 Record review of Resident #21's Admission record revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses of hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease (the high blood pressure has damaged both the heart and kidneys, leading to significant impairment in kidney function and the heart's ability to pump blood effectively), cognitive communication deficit, insomnia (a sleep disorder that makes it difficult to fall asleep, stay asleep, or get enough quality sleep), depression, presence of coronary angioplasty implant and graft, secondary hyperaldosteronism (a patient has had a coronary angioplasty (procedure that uses a balloon to widen a blocked or narrowed coronary artery) procedure and a stent placed in their coronary artery), alcohol dependence, in remission, bipolar disorder, anxiety disorder, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris (a type of coronary artery disease (CAD) that occurs when plaque builds up in the walls of the heart's arteries. This buildup, also known as atherosclerosis, narrows the arteries and makes them less flexible. The narrowing can reduce blood flow to the heart, which can lead to angina pectoris, or chest pain.), and heart failure. Record review of Resident #21's quarterly MDS, dated [DATE], revealed the resident had mildly impaired cognition for daily decision making. Record review of Resident #21's care plan contained a care area, last edited on 11/18/24, that stated the resident had a history of alcohol or drug abuse as evidenced by recently tested positive with interventions to MD/RP will be notified of any changes in residents behavior / mental state. Record review of Resident #21's nursing note written by RN A, dated 11/17/24, stated res was very anxious and agitated. Pacing repeatedly. NP was notified and /her order a urine test for drugs was done He tested positive on our test her for amphetamines. A sample of his urine was also sent to the lab where it again came back positive for amphetamines. NP was notified by DON. Pending NP recommendations at this time During an observation on 11/20/24 at 11:29 a.m. urine drug screens collected from the residents on 11/16/24 at the facility were observed with the following results: Resident #9 positive for methamphetamine Resident #21 positive for methamphetamine (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #36 positive for amphetamines and methamphetamine Resident #40 positive for MDMA (Methylenedioxymethamphetamine or ecstasy), methamphetamine, and amphetamines Record review lab results collected on 11/16/24 and ran on 11/17/24 showed urine drug screen results for Resident #9, Resident #21, Resident #36, and Resident #40 were all positive for amphetamines. During an interview on 11/20/24 at 9:50 a.m. RN A revealed she would observe Residents #9, #21, #36, and #40 on the smoking patio huddled down and outside of designated smoking times. RN A stated Resident #40 had a visitor who would enter through an unlocked door in the back of the facility at any time - usually late in the evenings. Shortly after this visitor came, the above residents would begin to act differently with exaggerated movements and posturing, odd behaviors, and more aggression. RN A stated she was concerned about the unlocked doors at the facility because strangers would sometimes just sit inside the facility. RN A stated she had reported these concerns to management, but they never addressed them. During an interview on 11/20/24 at 10:11 a.m. LVN B stated she began to notice Resident #36 was having behaviors that were not normal for her. LVN B stated she noticed it was always after she was hanging out with a group of residents that included Resident #9, #21, and #40. LVN B stated they would go out on the smoking patio outside of smoking hours unsupervised and smoke. LVN B stated on 11/3/24 Resident #36 began acting strange and she notified NP D who ordered a blood panel to test for drugs. LVN B said there was a long delay in obtaining the blood panel drug test results and they still did not have those. LVN B stated while she had no proof that Resident #40 was suppling drugs to other resident's she suspected it was him because other residents would always visit him in his room, and he sometimes had a late-night visitor who would enter through the back unlocked door. LVN B stated Resident #36 had a history of Angina and recently had an abnormal EKG and had been a resident there for a long time and never behaved like this before. LVN B stated on 11/15/24 she observed Resident #36 run into the hallway and yell that she was too high. LVN B stated Resident #36 was tested along with Resident #9, #21, and #40 on 11/16/24 and they all tested positive for amphetamines. LVN B stated the residents initially tested positive for MDMA, meth, and amphetamines. During an interview on 11/20/24 at 10:40 a.m. the DON stated on 11/3/24 Resident #36 began acting erratic but denied any drug use. The DON stated they did collect a blood sample for drug testing but had issues with getting results from the lab. The follow week Resident #36 was again acting erratic and they sent her to the hospital for chest pain. The DON stated CNA C told staff she overheard Resident #40 was this what you want and Resident #36 said yes. The DON stated after that Resident #36 was heard yelling in the hallway that she was too high. The DON said later the NP ordered urine drug screening on all residents who were hanging out in the group together (Resident #9, #21, #36, and #40). The DON stated they did in house ones that showed multiple drugs in their systems and also sent the urine to the lab that showed just amphetamines in their systems. The DON stated she notified the Administrator. The DON stated they did call the police to come search for drugs and none were found on any of the residents involved. The DON stated she did not think the Administrator reported the drug use to the stated because the ombudsman told them they did not need to report it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 11:35 a.m. the Administrator stated corporate and the ombudsman came on Monday 11/18/24 to discuss what to do about all the residents who tested positive for amphetamines. He was planning to reach out to the PM because they were unsure what this would be reported under if necessary to report to the state. The Administrator stated they used the SUD policy for guidance on how to handle the residents who were using amphetamines. The Administrator stated they could not find anywhere that stated they needed to report this to the state because the residents took the drugs because they wanted to and it was not coercion. The Administrator stated the company used to lock the doors but they since had changed the policy and that was why they do not accept wanderers at the facility. The Administrator stated they preferred to keep the doors unlocked to keep a home like environment and so they can have visitors. The Administrator stated he felt it was safe to have the doors unlocked because they are always watching them. The Administrator stated he has heard of times that residents are on the back patio smoking unsupervised and him and the ombudsman have reviewed the smoking policy with the residents and had them sign on 8/28/24. The Administrator stated all residents should be supervised while smoking per policy and if they are unsupervised it was because they are sneaking out. The Administrator stated it was a constant issue that residents smoke unsupervised and he has asked the ombudsman if he can do a 30 day discharge or immediate if they are violating the smoking policy. The Administrator stated he did not think locking the doors would make a difference on residents having access to areas unsupervised because if they want to do something they are going to find a way to do it. The Administrator stated after the 4 residents tested positive for amphetamines on 11/16/24 they called law enforcement to investigate the drug use on 11/18/24 and no drugs or paraphernalia were found. During an interview on 11/20/24 at 12:30 p.m. the ombudsman stated he had discussed with the facility what they would need to report this under if they reported it to the state but he did not specifically tell them not to report it. The ombudsman stated he told the facility they could not discharge Resident #40 who they suspected was distributing the drugs to other resident because they did not have proof. Record review of the facility's policy titled Abuse Prevention Program, dated 12/2016, stated Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation As part of the resident abuse prevention, the administration will:1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual .7. Investigate and report any allegations of abuse within timeframes as required by federal requirements;

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

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 45857

Based on interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 5 of 16 residents (Resident #9, Resident #21, Resident #36, Resident #40 and Resident #48) reviewed for accidents and supervision.

The facility failed to provide adequate supervision to Resident #36 after Resident #36 was suspected to be under the influence of illicit substances. Resident #9, Resident #21, Resident #36, and Resident #40 all tested positive for amphetamines. The facility did not lock and adequately supervise the back door. Further observation revealed Resident #9 and Resident #48 were smoking outside unattended.

An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 1:10 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm because the facility needed to monitor the implementation of the plan of removal.

The failure placed all residents at risk for serious injury, harm, and/or death.

The findings included:

1. Record review of Resident #9's Admission record revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses of chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe. It's caused by damage to the lungs that reduces airflow.), vascular dementia (a type of dementia that occurs when blood vessels in the brain are damaged, reducing the flow of oxygen and nutrients to the brain), mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, extrapyramidal and movement disorder (are a group of movement disorders that can occur as a side effect of certain drugs, particularly antipsychotics), nicotine dependence (a chronic disease that occurs when the body becomes addicted to nicotine, a stimulant found in tobacco products), schizophrenia (a chronic mental disorder that affects how people think, perceive reality, and interact with others), and insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get quality sleep).

Record review of Resident #9's quarterly MDS, dated [DATE], revealed the resident had fully intact cognition for daily decision making.

Record review of Resident #9's care plan contained a care area, last edited on [DATE], that stated the resident had a history of alcohol or drug abuse as evidenced by recently tested positive with interventions to MD/RP will be notified of any changes in residents behavior / mental state. Also, a care area for Resident #9 smokes cigarettes and he set a fire at the last placement due to hearing what he thought was a gun being loaded. He will have strictly supervised smoking breaks; no lighter will be in his possession with interventions to All smoking materials are kept at the nurse's station between smoke breaks, [Resident #9] will be given two cigarettes a break and offered a light-he will be supervised at all times during the break.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a nursing note written by LVN B, dated [DATE], stated It had been noted by staff that res had been acting abnormally. This nurse was given an order to test urine for drugs. Urine came up positive for amphetamines . Record review of Resident #9's Psychotherapy progress notes, dated [DATE], stated Focus of Session: individual psychotherapy session with patient in his room and [nursing facility]. Patient was reportedly involved in an incident over the weekend but did not bring it up during the therapy session. The issue was not pressed. Patient reports that he is doing OK and that he is getting ready to go on his smoke break once this session is over. Patient reports good sleep, good appetite and patient reports that he is no longer depressed. He reports that he is still tired and lethargic most of the time. Encourage patient to be patient with adjustment. Period for new medications 2. Record review of Resident #21's Admission record revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses of hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease (the high blood pressure has damaged both the heart and kidneys, leading to significant impairment in kidney function and the heart's ability to pump blood effectively), cognitive communication deficit, insomnia (a sleep disorder that makes it difficult to fall asleep, stay asleep, or get enough quality sleep), depression, presence of coronary angioplasty implant and graft, secondary hyperaldosteronism (a patient has had a coronary angioplasty (procedure that uses a balloon to widen a blocked or narrowed coronary artery) procedure and a stent placed in their coronary artery), alcohol dependence, in remission, bipolar disorder, anxiety disorder, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris (a type of coronary artery disease (CAD) that occurs when plaque builds up in the walls of the heart's arteries. This buildup, also known as atherosclerosis, narrows the arteries and makes them less flexible. The narrowing can reduce blood flow to the heart, which can lead to angina pectoris, or chest pain.), and heart failure. Record review of Resident #21's quarterly MDS, dated [DATE], revealed the resident had mildly impaired cognition for daily decision making. Record review of Resident #21's care plan contained a care area, last edited on [DATE], that stated the resident had a history of alcohol or drug abuse as evidenced by recently tested positive with interventions to MD/RP will be notified of any changes in residents behavior / mental state. Record review of Resident #21's nursing note written by RN A, dated [DATE], stated res was very anxious and agitated. Pacing repeatedly. NP was notified and /her order a urine test for drugs was done He tested positive on our test her for amphetamines. A sample of his urine was also sent to the lab where it again came back positive for amphetamines. NP was notified by DON. Pending NP recommendations at this time Record review of Resident #21's Psychotherapy Progress note, dated [DATE], stated Focus of Session: individual therapy session with [Resident #21] in his room and [Nursing Facility]. Patient was referred for a follow up session today due to an incident that happened over the weekend. Patient was given opportunities to bring up anything that might've happened during the weekend, but he denied any significant event. Patient did discuss his chemo and the fact that it does make him nauseated at times. Patient reports he is not sleeping well and is only getting about five hours of sleep per night. Patient's appetite is good. Patient reports that he is doing OK, however, he presented with flat affect in this current session . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #21 Interview on [DATE] at 10:30 am - Resident was observed laying in his bed in his room, he refused to answer or talk about the drug use incident. 3. Record review of Resident #36's Admission record revealed a [AGE] year-old female admitted [DATE] and readmitted [DATE] with diagnoses of schizoaffective disorder (a chronic mental illness that involves symptoms of both schizophrenia and a mood disorder, such as bipolar disorder or depression), bipolar type, unspecified atrial fibrillation (a heart condition that causes the upper chambers of the heart to beat irregularly), unspecified convulsions (nerve cell activity in the brain is disrupted, causing muscles to involuntarily contract and spasm), extrapyramidal and movement disorders (a group of movement disorders that can occur as a side effect of antipsychotic and other drugs), bipolar disorder (a serious mental illness that causes extreme mood swings, along with changes in energy, thinking, behavior, and sleep), unspecified, recurrent depressive disorders, and major depressive disorder (a serious mood disorder that can affect how someone feels, thinks, and acts). Record review of Resident #36's quarterly MDS, dated [DATE], revealed the resident had mild cognitive impairment for daily decision making. Record review of Resident #36's care plan contained a care area, last edited on [DATE], that stated the resident had a history of alcohol or drug abuse with interventions to MD/RP will be notified of any changes in residents' behavior / mental state. Also, a care area for potential for safety hazards, injury related to smoking with an intervention to encourage resident to keep all smoking material at nurse's station after smoke break. Record review of Resident #36's nursing note written by LVN G, dated [DATE] stated As this nurse was administering morning medications, residents' vitals measured @ (BP),d+[DATE] and (P)134. Resident was observed as being overly skittish, could not stop moving while in the bed and acting paranoid that someone was trying to break into her closet and rest room, however there are no locks on her door handles. This nurse performed neuro check on resident and noted left pupil measuring at 6 mm and right pupil measuring at 4 mm. Resident admitted to this nurse that she had been drinking wine, smoking cigars and vaping throughout the night, resident was reminded that she should not be smoking outside of designated smoke times and she should not be holding cigarettes, lighters or vapes on her person. NP [D] notified of residents' condition; order given to have resident sent out to ER. 911 called, EMS arrived, and resident refused to go to hospital. EMS personnel stated that since she is alert enough to answer their questions and is refusing to be transported to hospital, they cannot take her. NP [D] notified of residents' refusal, NP gave orders for STAT labs CBC, BMP and blood drug panel, also monitor vitals every 30 mins for 3 hours. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #36's progress note, dated [DATE], written by NP D stated Seen today per request from Charge Nurse reporting that resident was up all night long on back outdoor patio unsupervised with other residents and has since had erractic behavior, AMS, jerking of arms and legs, twitching of neck, exhibiting paranoid behavior that someone was breaking into her closet. Nurse reported that pupils dilated to 6 mm at 05:37am. Resident admitted to drinking alcohol after she was told 2 weeks prior that this would have adverse effect to her mental status and serious health consequences due to all psychoactive medications, antidepressants, and anxiolytics. Patient made comment to nurse at 05:37 am that she was not doing drugs. Requested patient to be transferred to hospital for evaluation due to severe AMS but when EMS arrived, patient refused to go. Patient seen this afternoon and she is complaining rapid heart rate, SOB, chest tightness. She is still having constant movement of arms and legs, worming around in bed. She made the comment again that I have not done any drugs when patient questioned about chest pain. Record review of Resident #36's nursing note written by LVN G, dated [DATE], stated At beginning of this shift, during report, resident observed in wheelchair at nurses' station having erratic behavior and movement. Resident requested to have staff assist her to her room, once in room resident was heard yelling I'm too high, oh God help me. This nurse and day shift nurse assessed resident; resident admitted she had taken a pill that a man had given to her. 911 called. EMS arrived and resident taken to [hospital]. Resident did ask for staff to notify her sister before leaving facility. NP/DON/Administrator/[family member]. Record review of Resident #36 nursing note written by LVN B, dated [DATE], stated Res had been sent to hospital for erratic behavior on the 15th. This nurse came to work on the 16th and PA had given orders for urine drug screening. Urine collected and res tested positive for amphetamines . Record review of CNA C's statement dated [DATE] on stated I was in the bathroom and heard some people talking and heard a man (Resident #40) asking the lady (Resident #36) in the bathroom which one do you want and I guess she took whatever he gave her. Record review of Resident #36's Psychiatric progress note, dated [DATE], stated Patient is being seen today as a follow up on psychiatric services due to her psychotropic medication management, and psychiatric diagnosis of bipolar disorder, insomnia, major depressive disorder She has a pertinent history of bipolar disorder, multiple mental health hospitalization s, and suicide attempts .Trauma History: reported positive, was a prostitute, was incarcerated, can become physically violent. Substance Use: remote history, was in recover program. illicit drug use: remote history, was in recover program. Tobacco use: quit .Diagnosis #4 substance use disorder -patient had a sponsor in Houston, went to a 12-step program. It's not currently using (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #36's hospital documents, dated [DATE], stated [AGE] year-old female brought n by EMS from [NAME] winds skilled nursing facility due to altered mental status. She has a history of schizophrenia. There was concern the patient had taken an unknown medication but EMS reports it was her Xanax. Patient had been complaining of feeling like she had bugs in her hair and on her body. When I went to evaluate her she was sleeping soundly but upon awakening she states that she still feels like she has bugs in her hair, Patient was easily redirectable XXX[AGE] year-old female with history of schizophrenia presenting having an episode of difficult control at the skilled nursing facility. She had taken her Xanax prior to departure and upon, arriving here was calm and directable. She was sleeping comfortably. Vital signs were normal. No indication for further diagnostic evaluation or therapeutic intervention. Patient appears to be at her baseline. Do not suspect sepsis, intracranial hemorrhage, or other acute organic condition. Will discharge patient back to her skilled nursing facility for ongoing care of her underlying condition, currently stable and safe for discharge Record review of Resident #36's Psychotherapy Progress note, dated [DATE], stated .Focus of Session: individual psychotherapy session with [Resident #36] in her room and [Nursing Facility]. Patient was reportedly involved in a situation over the weekend that was potentially compromising. Met with the patient to observe and assess for emotional unrest. Patient did not indicate any out of the ordinary occurrence over the weekend. The issue was not pressed. Patient reports that she needs her eyeglasses fixed and she feels sick to her stomach. Patient reports that she sleeps. OK, maybe too much. Patient denies having a good appetite and report she is not doing as much in the facility as she used to . During an interview on [DATE] at 2:44 p.m. Resident #36 stated Resident #40 and her snorted white powder off her phone last Friday the 15th of November. Resident #36 stated Residents #9, #21 #40, and #48 would smoke drugs from a pipe on the back patio when staff were not around. 4. Record review of Resident #40's Admission record revealed a [AGE] year-old male admitted [DATE] with diagnoses of chronic obstructive pulmonary disease, disruption of external operation (surgical) wound, acquired absence of right leg below knee, acquired absence of left leg above knee, and depression. Record review of Resident #40's care plan contained a care area, last edited on [DATE], that stated the resident had a history of illicit drug use/abuse with interventions to MD/RP will be notified of any changes in resident's behavior/mental state. Also, a care area for potential for safety hazard, injury related to smoking. Resident assessed to be a supervised smoker. Resident smokes traditional cigarettes. Interventions included Encourage resident to keep all smoking material at nurse's station after smoke break. Record review of Resident #40's progress notes, revealed a note dated [DATE] for [DATE], written by NP F, stated Questionable activities reported that pt may be bringing unknown substance and giving it to other residents, his drug screen is pending . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #40's Psychotherapy Progress note, dated [DATE], stated .History of Present Illness: Patient came to the facility following an amputation of leg. Patient has a dx of .depression unspecified in his history. Patient was referred for assessment an reduction of inappropriate behaviors. Staff description of Patient Behavior: noncompliant uncooperative. Substance Misuse: client denies substance abuse Risk factors and summary of findings. Narrative: individual psychotherapy session with patient in his room. Patient was alert and presented as dysphoric and with flat or sad effect. Patient is in the facility due to amputation of legs. Patient reports that he is depressed most every day and anxiety is present some days. Patient has some issues with appetite and sleep. Patient denies any suicidal ideation or psychiatric inpatient care. Patient is a current smoker and denies alcohol or drug abuse. Patient is Patient PHQ9 score (is a depressive symptom scale and diagnostic tool) at present time is a nine. Patient is divorced. Has three girls, obtain an associate's degree on electronics, and was a delivery driver most of his life Record review lab results collected on [DATE] and ran on [DATE] showed urine drug screen results for Resident #9, Resdient #21, Resident #36, and Resident #40, were all positive for amphetamine. [DATE] at 10:40 am - Resident #40 interview - resident refused to answer or talk about the drug abuse incident. He just shook his head no. 5. Record review of Resident #48 face sheet dated [DATE] for Resident #48 showed an admitted [DATE] with diagnosis of Cerebral Infarction (mini stroke), Epilepsy (chronic brain disease that causes seizures), and Diabetes (chronic disease where the body doesn ' t produce enough insulin). Record review of Resident #48 ' s MDS dated [DATE] showed a BIMS score of 14 indicating the resident has normal cognitive functioning. Record review of Resident #48 ' s Care Plan dated [DATE] revealed, Potential for safety hazard, injury related to smoking. Record review of Resident #48 ' s Smoking assessment dated [DATE] revealed a score of 13 which indicated resident is Potentially unsafe smoker. During an observation on [DATE] at 11:07 am - Resident #48 and Resident #9 were observed smoking unsupervised for about 15 minutes. No staff were present at the time. During an interview on [DATE] at 11:09 am, Resident #48 - when asked where he got his cigar and how he lit it, he stated that he had it previously and that sometimes he doesn ' t smoke it all and saves it. He stated that he already had the old cigar and that a guy walking by lit it for me. During an interview on [DATE] at 11:00 am with the DON, she stated that smoke breaks are timed. Residents go about 6 times a day. Staff should be present when residents smoke. Staff keep the residents ' cigarettes and lighters. Policy stated they will be discharged if they are unsupervised. Told by corporate not to lock the doors anymore which allows residents to go outside whenever they want. Potential for harm could be an injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:43 am with the Administrator, he stated that residents who go outside alone to smoke, we are addressing it with the ombudsman. They are re-educating residents regarding smoking rules. He had a meeting with all the resident who smoke, and they signed the smoking policy about a month ago. Smoking residents should always be supervised regardless of whether they are deemed safe or not. Regarding residents who go out to smoke by themselves, it is frustrating because it does happen due to the doors not being locked. During an observation on [DATE] at 11:07 a.m. Resident #48 and Resident #9 were observed smoking unsupervised for about 15 minutes. No staff were present at the time. Observation on [DATE] at 4:34 p.m. revealed an unlocked door lead to the smoking area on the back side of the facility. There was no fence around the perimeter of the facility. The smoking area had open access to a sidewalk, neighborhood street, and houses across the street. The back door was unlocked for entry at any time. During an interview on [DATE] at 9:50 a.m. RN A revealed she would observe Residents #9, #21, #36, and #40 on the smoking patio huddled down and outside of designated smoking times. RN A stated Resident #40 had a visitor who would enter through an unlocked door in the back of the facility at any time - usually late in the evenings. Shortly after this visitor came, the above residents would begin to act differently with exaggerated movements and posturing, odd behaviors, and more aggression. RN A stated she was concerned about the unlocked doors at the facility because strangers would sometimes just sit inside the facility. RN A stated she had reported these concerns to management, but they never addressed them. During an interview on [DATE] at 10:11 a.m. LVN B stated she began to notice Resident #36 was having behaviors that were not normal for her. LVN B stated she noticed it was always after she was hanging out with a group of residents that included Resident #9, #21, and #40. LVN B stated they would go out on the smoking patio outside of smoking hours unsupervised and smoke. LVN B stated on [DATE] Resident #36 began acting strange and she notified NP D who ordered a blood panel to test for drugs. LVN B said there was a long delay in obtaining the blood panel drug test results and they still did not have those. LVN B stated while she had no proof that Resident #40 was suppling drugs to other resident's she suspected it was him because other residents would always visit him in his room, and he sometimes had a late-night visitor who would enter through the back unlocked door. LVN B stated Resident #36 had a history of Angina and recently had an abnormal EKG and had been a resident there for a long time and never behaved like this before. LVN B stated on [DATE] she observed Resident #36 run into the hallway and yell that she was too high. LVN B stated Resident #36 was tested along with Resident #9, #21, and #40 on [DATE] and they all tested positive for amphetamines. LVN B stated Resident #36 initially tested positive for MDMA, meth, and amphetamines. (continued on next page)

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	676301	A. Building B. Wing	11/23/2024

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:32 p.m. NP D stated she was informed on [DATE] that Residents #9, #21, #36, and #40 were out on the patio all night on [DATE] unsupervised. NP D stated they became suspicious that drug use was going on because resident #36's behaviors and mannerisms were different, and she stated she was not using drugs during her assessment of the resident. NP D stated she told facility staff she did not want patients under her care outside unsupervised all night because they have access to the community. NP D stated it was unhealthy for them to be up all night because many of them are on medications to help them sleep, are on psychiatric medications, and will miss out on ADLs, activities, and meals during the day. NP D stated these Residents were in a nursing home for a reason and should not be left unsupervised in the middle of the night. NP D stated she knew Resident #36 had a history of drug use and inquired why resident #36 used drugs again after a long period of sobriety and Resident #36 stated because of who she was hanging out with and because she had access to the drugs at the facility. NP D stated Resident #36 had a history of angina but in the past few months had an increase in chest pain complaints. NP D stated she had since educated the resident that amphetamines are bad for her heart and could lead to a heart attack or death. NP D stated Resident #36 had an abnormal EKG on [DATE] when she was sent to the ER after suspected drug use and seen for chest pain. During an interview on [DATE] at 10:40 a.m. the DON stated on [DATE] Resident #36 began acting erratic but denied any drug use. The DON stated they did collect a blood sample for drug testing but had issues with getting results from the lab. The follow week Resident #36 was again acting erratic and they sent her to the hospital for chest pain. The DON stated CNA C told staff she overheard Resident #40 was this what you want and Resident #36 said yes. The DON stated after that Resident #36 was heard yelling in the hallway that she was too high. The DON said later the NP ordered urine drug screening on all residents who were hanging out in the group together (Resident #9, #21, #36, and #40). The DON stated they did in house ones that showed multiple drugs in their systems and also sent the urine to the lab that showed just amphetamines in their systems. The DON stated she notified the Administrator. The DON stated they did call the police to come search for drugs and none were found on any of the residents involved. The DON stated she did not think the Administrator reported the drug use to the stated because the ombudsman told them they did not need to report it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:35 a.m. the Administrator stated corporate and the ombudsman came on Monday [DATE] to discuss what to do about all the residents who tested positive for amphetamines. He was planning to reach out to the PM because they were unsure what this would be reported under if necessary to report to the state. The Administrator stated they used the SUD policy for guidance on how to handle the residents who were using amphetamines. The Administrator stated they could not find anywhere that stated they needed to report this to the state because the residents took the drugs because they wanted to and it was not coercion. The Administrator stated the company used to lock the doors but they since had changed the policy and that was why they do not accept wanderers at the facility. The Administrator stated they prefer to keep the doors unlocked to keep a home like environment and so they can have visitors. The Administrator stated he felt it was safe to have the doors unlocked because they are always watching them. The Administrator stated he has heard of times that residents are on the back patio smoking unsupervised and him and the ombudsman have reviewed the smoking policy with the residents and had them sign on [DATE]. The Administrator stated all residents should be supervised while smoking per policy and if they are unsupervised it was because they are sneaking out. The Administrator stated it was a constant issue that residents smoke unsupervised and he has asked the ombudsman if he can do a 30 day discharge or immediate if they are violating the smoking policy. The Administrator stated he did not think locking the doors would make a difference on residents having access to areas unsupervised because if they want to do something they are going to find a way to do it. The Administrator stated after the 4 residents tested positive for amphetamines on [DATE] they called law enforcement to investigate the drug use on [DATE] and no drugs or paraphernalia were found. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled Safety for Residents with Substance Use Disorder, dated , d+[DATE], stated It is the policy of this facility to create an environment as free of accident hazards as possible for residents with a history of substance use disorder. Definitions: Substance Use Disorder (SUD) is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Policy Explanation and Compliance Guidelines: 1. Residents with a history of SUD will be assessed for risks including the potential to leave the facility without notification and use of illegal/prescription drugs. Care plan interventions will be implemented to include increased monitoring and supervision of the resident and their visitors. 2. When substance use is suspected, (in the facility or upon return from an absence from the facility) which could lead to overdose, facility staff should implement the care plan interventions, which includes notification of the resident's physician or non-physician practitioner. 3. Care planning interventions will address risks by providing appropriate diversions for residents and encouraging residents to seek out facility staff to discuss their plan of care, including discharge planning, rather than leaving to seek out substances which could endanger the resident's health and/or safety . 6. Residents with SUD may try to continue using substances during their stay in the nursing home. Facility staff will assess the resident for the risk for substance use in the facility and have knowledge of signs and symptoms of possible substance that include, but are not limited to: a. Frequent leaves of absence with or without facility knowledge b. Odors c. New needle marks d. Changes in resident behaviors, especially after interaction with visitors of absences from facility . 7. The facility will make an effort to prevent substance use which may include providing substance use treatment services, such as behavioral health services, medication-assisted treatment (MAT), alcoholic/narcotics anonymous meetings, working with the resident and the family, if appropriate, to address goals related to their stay in the nursing home, and increased monitoring and supervision. 8. Staff will be prepared to address emergencies related to substance use by maintaining and having knowledge of administering opioid reversal agents like naloxone, initiating CPR as appropriate, and contacting emergency medical services as soon as possible. Record review of a facility policy titled Smoking policy, dated ,d+[DATE], showed Residents may not have or keep any smoking articles ., The facility may impose smoking restrictions on a resident at anytime if it is determined that the resident cannot smoke safely or use smokeless tobacco with the available levels of support and supervision. An Immediate Jeopardy was identified on [DATE]. The Administrator and the DON were notified of the Immediate Jeopardy on [DATE] at 1:10 p.m. and were given a copy of the IJ template and a Plan of Removal (POR) was requested. The facility's Plan of Removal for the Immediate Jeopardy was accepted on [DATE] at 10:45 a.m. and reflected the following: Summary of Details which lead to outcomes. On [DATE], during a standard survey [facility]. A surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the facility constitute immediate jeopardy to resident health. Problem: Failed to provide adequate supervision (F689) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan: 1). [DATE]: Administrator/Designee re-educated residents who smoke individually on the smoking policy. The facility has an updated list of residents who smoke and once re-educated it is documented in the resident's electronic health record. Completion date [DATE] 2). [DATE]: DON/Designee presented re-education individually to each licensed and certified staff on substance use disorder to include signs of substance abuse using the facility policy to include notifying the Charge Nurse/Supervisor resident exhibiting signs of substance abuse. Facility is utilizing an employee roster to track licensed and certified staff in-service. Completion date [DATE] 3). [DATE]: DON/Designee presented In-service to all staff on supervised smoking policy to include smoking times, locations, and what to do when a resident is observed smoking unattended. Any staff not currently working will be contacted via phone. Completion date [DATE]. DON/designee will monitor to ensure staff have received the in-service training. [DATE] at 11:00 am - Observation of residents #9, #48, #21, #31, #41, #40 were observed smoking with staff present. No discrepancies noted. 4. [DATE]: DON/Designee re-educated the four residents identified on the IJ template (Resident [TRUNCATED]

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45857

Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 2 of 2 (Resident #29 and Resident #163) reviewed for respiratory care.

1. The facility failed to ensure Resident #29 had a oxygen sign posted on his door to alert he had an oxygen tank and concentrator in his room.

2. The facility failed to post a sign to show Resident #163 had oxygen in use. The facility failed to ensure Resident #163 had an active order for oxygen. The facility failed to ensure Resident #163 oxygen tubing was not on the floor.

This deficient practice could place residents at risk for an increase in respiratory complications and make other unaware oxygen is in use.

The findings included:

1. Record review of Resident #29's admission record dated 11/22/24, revealed a [AGE] year old male resident was admitted on [DATE] and readmitted on [DATE] with diagnosis of acute respiratory failure with hypercapnia (the lungs are unable to adequately remove carbon dioxide from the body, leading to a dangerously high level of carbon dioxide in the blood), acute lower respiratory infection, shortness of breath, personal history of pulmonary embolism (a blockage in a lung artery caused by a blood clot that has traveled from elsewhere in the body), and chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breathe and worsen over time).

Record review of Resident #29's significant change MDS, dated [DATE], revealed the resident had mildly impaired cognition for daily decision making and had intermittent oxygen therapy.

Record review of Resident #29's care plan contained a care area, last edited on 11/04/24, that stated the resident had oxygen therapy required oxygen as needed to keep SPO2 at 90% or greater with interventions that included administer oxygen as ordered.

Record review of Resident #29's physician orders showed an order for PRN oxygen 2-4 L via nasal cannula as needed with a start date of 8/24/24 and no end date.

During an observation on 11/19/24 at 11:46 p.m. an oxygen tank was observed in Resident #29's room and an oxygen concentrator. No sign was posted in or around the room that oxygen was present.

Record review of Resident #163's admission record dated 11/22/24, revealed a [AGE] year-old male resident was admitted on [DATE] and readmitted on [DATE] with diagnosis of acute respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately oxygenate the blood, leading to a dangerously low level of oxygen in the body) and heart failure.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #163's quarterly MDS, dated [DATE], revealed the resident had fully intact cognition for daily decision making and had oxygen therapy while a resident. Record review of Resident #163's care plan contained a care area, last edited on 11/12/24, showed the resident was at risk for decreased cardiac output related to changes in myocardial contractility with interventions to administer oxygen as prescribed and monitor O2 daily. 2. Record review of Resident #163's physician orders, dated 11/22/24, revealed only an order for Change Humidifier, Nasal Cannula/Mask, and Oxygen tubing every week on Sunday with a start date of 5/28/24 and no end date. During an observation on 11/20/24 at 9:40 a.m. Resident #163 was in bed with an oxygen cannula on his nose. There was no sign posted in or around the room to show the resident had oxygen. There was no date on the oxygen tube or on the bottle of water. There was a nasal cannula tube on the floor in the room next to the resident dresser. The oxygen was on 2 liters per min. During an interview on 11/20/24 at 9:42 a.m. RN A stated the oxygen tube and water should be dated. RN A stated the water should be dated to ensure it was changed every day. RN A stated the resident returned to the facility overnight and an agency nurse most likely set up the oxygen and did not date it. RN A stated there should be signage on all resident rooms to alert staff the resident has oxygen for general awareness to look for it and check on it. During an observation on 11/20/24 at 10:37 a.m. the DON was observed going down the A hallway with a stack of oxygen signs and hanging them on resident rooms. During an interview on 11/21/24 at 12:05 p.m. the DON stated the facility does not date the oxygen tubes or water because they document it in the MAR or TAR. The DON stated all residents with oxygen should have signs and oxygen tubes that are not in use should be put in a bag or thrown away and not on the floor. Record review of the facility's policy titled Oxygen Administration, dated 10/2010, stated The purpose of this procedure is to provide guidelines for safe oxygen administration .preparation 1. Verify there is a physician's order for this procedure. Review physician's orders, facility protocol for oxygen administration .Equipment and supplies 4. No smoking/Oxygen in Use signs .Steps in procedure .2. Place oxygen in use sign on the outside of the room entrance door. Close the door .12. Check the mask, tank, humidifying bottle and that the water level is high enough that the water bubbles as oxygen flows .14. Periodically recheck water level in humidifying bottle. 15 Discard used supplies into designated containers .

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NAME OF PROVIDER OR SUPPLIER: Autumn Winds Living & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3301 Fm 3009 Schertz, TX 78154	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 Based on interviews and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 3 of 4 residents (Resident #9, Resident #25, and Resident #30) reviewed for psychotropic medications (medications that affect behavior, mood, thoughts, and perception). 1. The facility failed to obtain signed consents for psychotropic medications for Resident #9 who was administered paliperidone palmitate extended release injectable suspension (is an atypical antipsychotic indicated for the treatment of schizophrenia) and paliperidone orally daily and required a written signature on the Nursing Facility Consent for Antipsychotic or Neuroleptic Medication Treatment form. 2. The facility failed to obtain signed consent for Resident #25's psychiatric medications and explain the possible side effects to a responsible party who could make an informed decision for trazadone (medication is used to treat depression), paroxetine (antidepressant that belongs to group of drugs called selective serotonin reuptake inhibitors (SSRIs). Paroxetine affects chemicals in the brain that may be unbalanced in people with depression, anxiety, or other disorders.) and buspirone (anxiolytic, a medication primarily used to treat anxiety disorders) that were administered to her. 3. The facility failed to obtain signed consents for psychotropic medications for Resident #30 who took seroquel and ABH (Ativan, Haldol and Benadryl) gel, and required written signatures on the Nursing Facility Consent for Antipsychotic or Neuroleptic Medication Treatment form. These failures could affect residents who received psychoactive medications without informed consents and place residents at risk of receiving unnecessary psychotropic medications. Findings included: 1. Record review of Resident #9's Admission record revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses of vascular dementia (a type of dementia that occurs when blood vessels in the brain are damaged, reducing the flow of oxygen and nutrients to the brain), mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, extrapyramidal and movement disorder (are a group of movement disorders that can occur as a side effect of certain drugs, particularly antipsychotics), schizophrenia (a chronic mental disorder that affects how people think, perceive reality, and interact with others), and insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get quality sleep). Record review of Resident #9's quarterly MDS, dated [DATE], revealed the resident had fully intact cognition for daily decision making and took antipsychotics in the past 7 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's care plan contained a care area, last edited on 11/20/24, that stated the resident had schizophrenia with interventions to assist resident in identifying the effect of his behaviors on others and Restrict access to potentially harmful items (e.g., glass, scissors, needles, razors, plastic bags, lighters, hangers, knives, medications, call light cords, electrical appliances, etc.). Record review of Resident #9's November MAR dated 11/21/24 showed an order for - paliperidone tablet extended release 24hr; 9 mg; Amount to Administer: 1; oral with a start date of 7/30/24 and no end date. - . (paliperidone palmitate) syringe; 156 mg/mL; Amount to Administer: Inject 1ml=156mg; intramuscular with a start date of 10/31/24 and no end date. Record review of a form 3713 title Consent for Antipsychotic or Neuroleptic Medication Treatment, no date, stated Resident #9 took paliperidone 819 mg-2.625 ml every 90 days and paliperidone 9 mg every day for schizophrenia. The form was signed by a doctor and a health care professional proposing the treatment, they did not date the document. The portion of the document for the resident or resident's representative signature and date were blank. Record review of a document titled, Consent for Antipsychotic or Neuroleptic Medication Treatment 1, dated 7/2/24, showed Resident #9 took 9 mg of paliperidone daily and 156 mg/ml of paliperidone every month for schizophrenia. The document was signed by NP D on 7/2/24. The area for the Resident or Resident representative signature stated, Phone Consent and was dated 7/2/24. 2. Record review of Resident #25's face sheet, dated 11/22/24, revealed a [AGE] year-old female admitted [DATE] and readmitted [DATE] with diagnoses of dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; depression, anxiety, insomnia, legal blindness, and major depressive disorder. Record review of Resident #25's quarterly MDS, dated [DATE], revealed the resident had mild cognitive impairment for daily decision making and took antidepressant in the last 7 days. Record review of Resident #25's care plan contained a care area, last edited 11/4/24 stated she took psychotropic drugs for depression and anxiety with an intervention to monitor the resident's mood and response to medication and review pharmacy consults. Another area stated she or her representative expressed desire for long term placement at this facility. related to: advanced disease process/condition; visual impairment; cognitive impairment; mood/behavior problem; assistance with all ADLS with intervention of provide me and or my representative education . Record review of Resident #25's active physician orders, dated 11/22/24, showed orders for: -Buspirone tablet, 5 mg, 1 tablet oral three times a day, with a start date of 5/28/24 and no end date. -Paroxetine hcl, 30 mg, 1 tablet oral once a day, with a start date of 6/7/24 and no end date. -Trazadone, 50 mg, oral at bed time, with a start date of 2/5/24, and no end date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a document titled Consent for Psychoactive Medications, dated 8/20/24, showed the resident took -2/5/24 - Trazodone - Insomnia - Antidepressant -6/7/24 - Paroxetine HCL - Depression - Antidepressant -5/28/24 - Buspirone - Anxiety - Antianxiety The form contained a typed name of Resident #25's family member. LVN J's name was typed on the form under facility representative signature and dated 8/20/24. During an interview on 11/22/24 at 3:04 p.m. Resident #25's family member stated Resident #25 resided at the nursing facility after APS placed her there due to her living conditions and need for personal assistance. The family member stated a different family member used to be Resident #25's representative but had passed away. The family member stated she was not sure what medications Resident #25 took and had never discussed what medication Resident #25 took with the facility or any possible drug allergies she had. The family member stated no one ever asked to consent to anything on Resident#25's behalf and she did not know why her name would be typed on a medication consent form. During an interview on 11/22/24 at 3:24 p.m. Resident #25 stated she did not know what medications she took or why she takes them. She stated no one had ever explained her medications to her or asked her permission to take any medications. Resident #25 stated she had no Representative because the sister who helped with her care had passed away. During an interview on 11/22/24 at 3:27 p.m. LVN J stated she was responsible for obtaining consents for residents who took psychiatric medications. LVN J stated Resident #25 had a family member who she would contact about the resident's care. LVN J stated the family member never came into the facility but consented over the phone to allow Resident #25 to take psychiatric medications. LVN J stated you could have a normal conversation with Resident #25 to an extent, but she did not think Resident #25 would understand consenting to taking psychiatric medications. LVN J stated she had no encountered a situation where a resident needed a representative or legal guardian but did not have one. LVN J stated the consent form was necessary to be acknowledged and signed to make sure the resident or resident representative were aware of the benefits vs the side effects of the medications. LVN J stated if they did not get consent for medications, they were required to they would be giving a resident medications they did not consent to. 3. Record review of Resident #30's Resident Face Sheet documented a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included opioid dependence with other opioid-induced disorder (chronic use of opioids that causes clinically significant distress or impairment), schizoaffective disorders (a mental health condition including schizophrenia and mood disorder symptoms), sarcoidosis (a condition that causes lumps or nodules to form in various parts of the body), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), chronic pain syndrome (persistent pain that may be caused by inflammation or dysfunctional nerves), unspecified osteoarthritis (a degenerative disease resulting in chronic pain), and sciatica (pain radiating along the sciatic nerve from lower back to one or both legs). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #30's medical record revealed an Observation Detail List Report consisting of a Consent for Antipsychotic or Neuroleptic Medication Treatment ordering Seroquel and ABH gel with the consent being obtained via telephone by Resident #30's Responsible Party. The form was dated 05/24/24. The form was not physically signed by the Responsible Party. Record review of Resident #30's medical record revealed an Observation Detail List Report consisting of a Consent for Antipsychotic or Neuroleptic Medication Treatment ordering Seroquel - 08/15/24. A typed signature dated 08/20/24 with the Responsible Party's name was entered under the line Resident/Family Signature. The form was not physically signed by the Responsible Party. Record review of Resident #30's medical record revealed an Observation Detail List Report consisting of a Consent for Antipsychotic or Neuroleptic Medication Treatment ordering ABH Cream on 08/27/24 which is an antianxiety and antipsychotic medication for the diagnosis of Schizoaffective disorder, had a completed date of 08/28/24. Under the line Resident/Family Signature was the Responsible Party's name typed with a date of 08/27/24. Record review did not reveal the required Form 3713 for written consent to receive an antipsychotic medication for any of the above medications. Record review of the facility's policy titled Psychotropic Medication Use, dated 7/22, stated Policy Statement Residents will not receive medications that are not clinically indicated to treat a specific condition. Policy Interpretation and Implementation . 1. A psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior. Drugs in the following categories are considered psychotropic medications and are subject to prescribing monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics; b. Anti-depressants; c. Anti-anxiety medications; and d. Hypnotics. 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences . 4. Residents (and/or representatives) have the right to decline treatment with psychotropic medications. a. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. 45857

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for 1 of 2 residents (Residents #30) reviewed for hospice services in that: The facility failed to maintain required hospice forms and documentation in the current hospice binders in the facility to ensure residents received adequate end-of-life care. This failure could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. The findings included: Record review of Resident #30's Resident Face Sheet documented a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included opioid dependence with other opioid-induced disorder (chronic use of opioids that causes clinically significant distress or impairment), schizoaffective disorders (a mental health condition including schizophrenia and mood disorder symptoms), sarcoidosis (a condition that causes lumps or nodules to form in various parts of the body), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), chronic pain syndrome (persistent pain that may be caused by inflammation or dysfunctional nerves), unspecified osteoarthritis (a degenerative disease resulting in chronic pain), and sciatica (pain radiating along the sciatic nerve from lower back to one or both legs). Review of Resident #30's Care Plan with the Last Reviewed/Revised date of 11/4/24, indicated resident was admitted to hospice on 11/04/24. Review of the hospice binder for the identified company for Resident #30 did not reveal the required hospice forms including Form 3071, Individual Election/Cancellation/Update or the Form 3074, Physician's Certificate of Terminal Illness. During an interview with the ADM on 11/22/24 at 9:44 am, ADM stated the hospice company had not provided the required forms. ADM stated the facility did not think they had to do the forms since Resident #30 was private pay for hospice and was Medicaid pending. The ADM also stated that no one in the facility had been assigned the responsibility of ensuring all the required paperwork for hospice was in the facility either in the hospice binder or uploaded to their electronic health record system. The ADM stated he would now be responsible for ensuring the required forms were present in the charts since no one had been assigned this responsibility. Review of the Hospice Policy dated July 2017 documented: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. Our facility has designated _____ (Name) _____(Title) to coordinate care provided to the resident by our facility staff and the hospice staff. (Note: this individual is a member of the IDT with clinical and assessment skills who is operating within the state scope of practice act). He or she is responsible for the following: d. Obtaining the following information from the hospice: (1) The most recent hospice plan of care specific to each resident; (2) Hospice election form; (3) Physician certification and recertification of the terminal illness specific to each resident; (4) Names and contact information for hospice personnel involved in hospice care of each resident; (5) Instructions on how to access the hospice's 24-hour on-call system; (6) Hospice medication information specific to each resident; and (7) Hospice physician and attending physician (if any) orders specific to each resident.