STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676332	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Medical Resort at Bay Area	4900 East Sam Houston Parkway South Pasadena, TX 77505

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 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 1 of 5 residents (Resident #19) reviewed for resident rights. The facility failed to obtain a signed consent for antipsychotic medication, Wellbutrin XL Oral Tablet Extended Release 24-hour 150 MG, administered to Resident #19. The failure affected residents who received psychoactive medications without informed consents and placed them at risk of receiving treatments without informed consent. Findings included: Record review of Resident # 19's face sheet provided by the facility on 10/31/2024 revealed that Resident # 19 [NAME] a 61 -year-old male who admitted to the facility on [DATE] and had an active diagnosis of bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) with an onset documented as of 09/05/2024. Record review of the comprehensive MDS assessment revealed Resident # 19's Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was able to complete the interview. The MDS assessment for Resident #19 revealed had an active psychotic disorder of bipolar disorder and had received an antipsychotic. Record review of Resident #19's physician's order summary report revealed the following order: Wellbutrin XL Oral Tablet Extended Release 24-hour 150 MG give one ablet by mouth one time a day for depression with a start date of 09/17/2024. Record review of Resident #19's MAR revealed Wellbutrin XL Oral Tablet Extended Release 24-hour 150 MG was administered by the facility's nursing staff on 09/17/2024 thru 09/25/2024 to Resident #19. (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview om 10/30/2024 at Nurse P stated that the provider is responsible for ensuring the resident is informed of the medications prescribed. He stated the nurse is responsible for ensure that a signed consent is obtained prior to administering medication. He stated the resident have the right to be informed of the treatment and medication provided. He stated that when a resident was not informed it deprived the resident of their right to understand the treatment plan, including potential risks, benefits, and alternatives. Interview on 10/30/2024 at 3:00 PM, the DON stated that the nurses were required to confirm that there [NAME] a signed Form 3713 consent for Wellbutrin XL Oral Tablet Extended Release 24-hour 150 MG. The DON stated the facility failed to obtain a consent on 09/17/2024. She stated the nurse is responsible for ensure that a signed consent is obtained prior to administering medication The DON stated she was made aware by Resident #19 that he was taking the medication. She stated that once she was made aware the provider was notified and the medication was discontinued on 09/25/2024, the day she was notified. The DON stated the failure placed the resident at risk for not being informed about his mediation and treatment he was receiving. The Medication Administration and Antipsychotic Medication Use/Consent Policy was requested. Interview on 10/31/2024 at 4:45 PM, the Administrator stated that the nurses [NAME] required to ensure that there was a signed consent for Antipsychotic Medication prior to administering. The Administrator stated the failure placed the resident at risk for not being informed about his mediation and treatment he was receiving. Interview on 10/30/2024 at 3:30 PM, Resident #19 stated the facility did not inform him he was taking Wellbutrin and he did not provide consent for the medication. He stated that he received antipsychotic medication but did not know the medications dosage and side effects associated with medications. He stated he learned he was taking the medication after he requested his medication record on 09/25/2024. He stated that he informed the DON that he did not consent to taking Wellbutrin and the medication was then discontinued. The facility failed to provide the facility policy for Psychoactive Medication Informed Consent.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 Based on observations, interviews, and record review, the facility failed to coordinate assessments with the Preadmission Screening and Resident Review (PASRR) program to the maximum extent practicable for 1 of 5 residents (CR #236) reviewed for PASRR. The NF was notified and instructed to submit a NFSS Request by a specific deadline but failed to do so. The NFSS Request submittal was denied and there was not a follow up submittal to ensure the request was approved to provide specialized services for PASRR for the CR #236 This failure could place residents requiring PASRR services at risk of not having their special needs assessed and met by the facility. Findings included: Record review of CR # 236's face sheet provided by the facility on 10/28/2024 revealed that CR # 236 [NAME] a 45 -year-old female who admitted to the facility on [DATE] and had an active diagnosis of Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) with an onset documented as of 01/29/2021. CR #236 discharged from the facility on 06/04/2024. Record review of the PASRR Level 1 Screening for CR #236 dated for 12/04/2023 indicated no mental health illness, intellectual disability, and developmental disability. It was determined that resident was eligible for PASRR specialized services. Record review of CR #236's care plan dated 08/19/2024 read in part CR #236 is dependent on staff for activities, cognitive stimulation, and social interaction related to cognitive deficits, physical limitations. Care Plan revealed no documentation of PASRR Specialized Services (Therapies and Assessments OT and PT) by 1/29/2024, DME for Mattress and CMWC (Customized Manual Wheelchair). Record review of email dated, 02/23/2024, HHS PASRR Program Specialist informed the facility of non-compliance with the requirements outlined in the Texas Administrative Code, Chapter 19, Subchapter BB, section S19.2704(i)(7)(A), which states facility must initiate nursing facility specialized services within 20 business days after the date that the services are agreed to in the IDT meeting for the resident we spoke about. The facility was instructed to submit a NFSS request form for PASRR Specialized Services (Therapies and Assessments OT and PT) by 1/29/2024, DME for Mattress and CMWC (Customized Manual Wheelchair) by 1/31/2024 through the Texas Medicaid and Healthcare Partnership (TMHP) Long Term Care Portal found. On 10/30/2024 at 11:00AM in an interview with DON, the DON stated that the MDS Coordinator is responsible for ensure that PASRR are completed. She stated that when the PASRR is not completed and submitted timely it could impact the resident's ability to receive PASRR specialized services and overall affect the resident's wellbeing. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/2024 at 11:20AM in an interview with the facility's Administrator, the Administrator stated that she was not aware of who was responsible for completing PASRR as she had only work at the facility for three days. She stated that PASRR should be completed timely and submitted to aid in the resident's ability to receive PASRR. She stated when PASRR wasn't completed and submitted for resident's who required specialized services the resident was at risk for not receiving the services needed. On 10/30/2024 at 1:00 PM in an interview and record review with MDS Coordinator revealed that she completed an updated PASRR Level 1 screening on 12/04/2023 prior to her employment with the facility. She stated that Resident #36's PASRR Level 1 screen was completed on 12/04/2024 but services were not provided. The MDS Coordinator stated she did not know why the NFSS follow up request was not submitted for CR #236. She stated that after speaking with the facility's corporate MDS she was informed that the NFSS Request was not submitted because CR #236 was identified as Medicaid Pending. She said that it would be important for a resident to receive PASRR services if they qualified. The MDS Coordinator said that the potential risk to a resident for not having the NFSS Request submitted, would be that the resident would not receive the necessary services the resident qualified for. Record review of the facility's Resident Assessment-Coordination with PASRR Program policy dated implemented 06/2023 and Date Revised: 06/2023 revealed 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review .b. A resident whose intellectual disability or related was not previously identified and evaluated through PASRR.

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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** 47709 Based on observations, interviews, and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 12 residents (Resident #132) reviewed for significant medication errors. The facility failed to ensure Metoprolol Tartrate (a blood pressure (BP) medication given to lower (high blood pressure) and treat heart failure) was administered on 10/28/2024 and 10/29/2024 to Resident #132 as ordered on 10/25/2024 by the physician. This failure could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, or a decline in health. Findings included: Record review of Resident #132's admission face sheet, undated, reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: hypertension (high blood pressure), heart failure (a chronic condition in which the heart not pumping blood as well as it should), and respiratory failure. Record review of Resident #132's baseline care plan dated 10/25/2024 reflected: Baseline Care plan summary: Resident #132 was alert and oriented. The resident's cognition was intact. Resident #132 received antihypertensives (medications used to treat high blood pressure). Resident #132's medication reconciliation (the process of ensuring a resident's hospital medications were reviewed and up to date) was completed. Resident #132's baseline summary reflected baseline care plan and medication list was reviewed with the resident and/or resident representative. Record review of Resident #132's Order Summary report active orders dated as of 10/30/2024 revealed Metoprolol Tartrate Tablet 25Mg. Give one by mouth in the morning for hypertension. Hold for SBP less than 110 and heart rate (HR) less than 60. Order dated 10/25/2024. Record review of Resident #132's October 2024 Medication Administration Record (MAR) dated 10/01/2024 -10/31/2024 reflected, the resident was not administered Metoprolol Tartrate 25 Mg when the physician's set parameter of SBP less than 110 and HR less than 60 were within parameters. The medication was held on: 10/28/2024 6:00-10:00 AM with BP 142/50 and HR 70 by MA A 10/29/2024 6:00-10:00AM with BP 115/50 and HR 72 by MA A Continued review of Resident #132's MAR revealed MA A coded 7 on 10/28/2024 and 10/29/2024. Review of the chart code revealed 7 indicted SBP below set parameters. Hold medications. Effective. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 10/30/2024 at 9:22 AM revealed Resident #132 in bed. Resident #132 was awake, alert, and oriented. Resident #132 stated she was getting her medicine good. Resident #132 stated they take good care of her, and she felt good. In a phone interview on 10/30/2024 at 11:35 AM the facility pharmacy representative stated the purpose of Metoprolol was to lower high blood pressure. The pharmacy representative stated the physician ordered the SBP and HR parameter because we do not want the BP to go too low. The pharmacy representative stated based on the ordered parameters and the resident's SBP and HR the medication should not have been held for those two days. The pharmacy representative stated the risk was they would not be treating the resident's condition and over time it could be a problem. In a phone interview on 10/30/2024 at 12:56 PM MA A stated she administered Resident #132's medications on 10/28/24 and 10/29/24. MA A stated she did not administer the Metoprolol because either the SBP or DBP was too low. MA A stated she believed she held it due to the resident's DBP being low, in the 50's. MA A stated she coded the dose as 7 due to her holding the medicine. The MA stated the risk of not giving the medication was the BP could go too high. In an interview and record review on 10/31/2024 at 11:21 AM the DON stated after review of Resident #132's physician's order, the Metoprolol should not have been held. The DON stated the DBP was low but there was no parameter set for the DBP. The DON stated she expected the physician's order and the ordered parameters to be followed. The DON stated the physician should have been called and asked if the medication should be held or administered. She stated to prevent this, they would reeducate staff on medication administration . In an interview on 10/31/2024 at 1:00 PM with the Administrator , she stated she expected the person administering the medications to be licensed or a trained MA. The Administrator stated she expected the physician's order to be followed. She expected the job to be done correctly. The Administrator stated the risk of not giving the blood pressure medication could cause the blood pressure to go high. The resident was at risk of a complication from high blood pressure like a stroke. She stated to prevent this again, they would retrain on medication administration. Record review of the facility policy titled Administering Medication revised dated April 2019 read in part . Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frames .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 16989 Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals used in the facility were secured properly for two residents (Resident# 14 and Resident #18) of five residents reviewed for pharmacy services. -The office of the ADON was open and accessible to staff and residents. There were two blister pack cards of controlled medications. Staff were within sight of the open door. The deficient practice placed the facility at risk for drug diversion. Findings included: Observation on 10/31/24 at 3:25 p.m. revealed the DON and the ADON left the ADON's office. They walked down Hall 300 and exited the facility. Observation revealed the office was adjacent to the nurses' station. Observation on 10/31/24 at 3:30 p.m. revealed there were five unidentified staff within sight of the open door. Continued observation from outside of the doorway revealed there was an over-bed table just inside the office. On the over-bed table was a laptop computer and two medication cards with count sheets secured around them with rubber bands. There was no staff in the office. The State Surveyor asked LVN G to accompany him into the office. Continued observation revealed the first card consisted of 77 tablets of Acetaminophen with Codeine for Resident #18. The second card consisted of 21 tablets of Norco 7.5/325 mg for Resident #14. LVN G verified the contents. Observation and interview on 10/31/24 at 3:33 p.m. revealed the DON and the ADON returned to the ADON's office. The DON said she had just left the room briefly and did not realize the door was not locked. The DON said the Acetaminophen with Codeine tablets were for Resident #18, who was just discharged from the facility. She said the Norco 7.5/325 mg tablets were for Resident #14, but the medication order was discontinued. The DON gathered the medications and took them to her office. In an interview on 10/31/24 at 3:50 p.m. the DON said a nurse (RN L) had brought her the medications. She said she was working on something else and got called away. She said she was away for three minutes. She said the two medications were controlled and should have been locked up. She said that anyone there could have taken them and created a drug diversion. In an interview on 10/31/24 at 3:56 p.m., the ADON said she was not aware that the medications were in her office. She said she would have locked the door had she known. She said someone could have taken one tablet or both of the cards. The person could have overdosed or had a negative health effect. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the National Institute of Health information sheet revealed Acetaminophen with Codeine was a Schedule III controlled medication. Review of the National Institute of Health National Library of Medicine information sheet revealed Norco 7. 5/325 mg was a Schedule III controlled medication. The facility policy Storage of Medications (revised November 2020) read, in part, .1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47709 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 for 1 kitchen. Food item was not sealed in the facility pantry . This deficient practice could place 25 residents who received meals from the main kitchen at risk for food borne illness. Findings included: Observation on 10/29/24 at 08:57 am revealed one 13.7-quart clear full-size container of brown sugar was left open to air. In an interview with the Dietary Manager on 10/30/2024 at 10:00 am, she said she noticed the brown sugar lid and the plastic wrapping was not covered on the container. She said when the workers leave the brown sugar uncovered it could cause the sugar to get hard and go bad fast. She said when the workers leave the container of brown sugar uncovered anything can crawl inside of it. She said anything at the top shelf can fall into the sugar which can cause cross contamination. She said she expected her workers to follow policy and procedures. In an interview with the [NAME] on 10/30/24 at 1:03 pm, she said she had been working at the facility for 6 years. She said when the brown sugar was left uncovered, she was moving fast and forgot to close it. She also said when the brown sugar was left open and uncovered with the lid off the container sugar could become contaminated because bugs can get into the sugar. She said moving forward she would slow down and make sure all the lids of the containers were properly stored which would prevent contamination. She said by properly storing the items it would prevent her from needing to throw away the food as well. In an interview with the Administrator on 10/31/2024 at 1:34pm, she said the cook informed her that she took out the brown sugar and forgot to replace the plastic wrapper and lid to cover the container. She said by the cook not covering the container bugs could get inside of it. She said once bugs get into the brown sugar it would become contaminated. She said the cook was in-serviced on properly covering and labeling items in the kitchen. Record review of the facility's Food Receiving and Storage Policy Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use . Dry foods that are stored in bins are removed from original packaging, labeled, and dated (use by date). Such foods are rotated using a first in - first out system. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the U.S. Food and Drug Administration dated 1/18/23 under Chapter 3 read in part . FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act.