STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676406	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trucare Living Centers - Selma	16550 Retama Parkway Selma, 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview and record review the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being for 2 of 4 residents (Residents #1 and #4) reviewed for care plans, in that: 1. The facility failed to ensure Resident #1's care plan was revised on (2) occasion, to reflect the use of bedrails, diagnosis of OSA, and the use of CPAP. 2. The facility failed to ensure Resident #4's care plan was revised on (2) occasions, to reflect the discontinuation of hospice services and diuretic medications. These failures could place residents at risk of current needs not being met. Findings included: 1. Record review of Resident #1's Admission Record, dated 9/24/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Cellulitis (common bacterial skin infection), Hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone), Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Obstructive Sleep Apnea (disorder that occurs when the upper airway partially /completely collapses leading to reduced/absent breathing during sleep), Hypertension (high blood pressure) and Atrial Fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow). Record review of Resident #1's Physical Device Consent and Acknowledgement, dated 9/5/24, revealed the resident signed consent for 1/4 bilateral side rails for generalized weakness and to improve mobility during transfers and repositioning. Record review of Resident #1's Progress Note, dated 9/5/24 and authored by LVN B, revealed: .Resident is bedbound at this time and is able help turn. 1/4 rails on bed to assist resident in repositioning . (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Side Rail/Mobility/Positioning Bar Assessment, dated 9/6/24 and authored by RN A, revealed the resident requested the use of 1/4 rails for general weakness or impaired mobility. Further review of this document revealed the resident was observed using the device on 9/5/24. The physician and DON were notified, and the intervention was care planned. Record review of Resident #1's comprehensive MDS assessment, dated 9/9/24, revealed the Resident #1 had a BIMS score of 15, suggesting intact cognition. Record review of Resident #1's Care Plan, dated 9/6/24, revealed the document did not include the use of a bedrails , CPAP, or diagnosis of OSA. Record review of Resident #1's Order Summary, dated 9/24/24, revealed the resident did not have an order for bedrails or CPAP. During an observation and interview on 9/24/24 at 12:58 PM, Resident #1 was lying in bed, cleaned/groomed, with no visible injuries. 1/4 rails were observed on the bed as well as a CPAP on the side table. Resident #1 said he had a CPAP. Resident #1 said he used the bed rails to help the staff with repositioning. During an interview on 9/25/24 at 1:54 PM, Resident #1 said he brought the CPAP from home, used it every night and applied it himself because the nurses refused to assist him due to not having an order. Resident #1's family member said she brought the CPAP to the facility when he was admitted but did not remember when that was. Resident #1's family member further stated he had been using the CPAP for at least [AGE] years. During an interview on 9/25/24 at 12:50 PM, LVN E said Resident #1 had a diagnosis of OSA, but this diagnosis/CPAP were not included in the care plan. During an interview on 9/25/24 at 2:04 PM, LVN A said she did not work overnight, but knew Resident #1 did have a CPAP which he used every night. During an interview on 9/25/24 at 2:58 PM, LVN B said Resident #1 was admitted to the facility on [DATE] and she had the resident sign the consent for the bedrails to assist with repositioning. During an interview on 9/25/24 at 3:45 PM, the DON said Resident #1 had bedrails, but they were not included in the care plan. The DON further stated the facility included bedrails in the care plans. The DON said she did not know why bedrails were not included in Resident #1's care plan. The DON said she did not know if Resident #1 had a CPAP and had not seen it in his room. The DON said CPAPs were usually included in the resident care plan. The DON stated Resident #1 had a diagnosis of OSA and she guessed this was why the family member brought in the CPAP. The DON said she was told by LVN B that Resident #1's family member brought his CPAP, but she didn't know he had it. The DON further stated she was responsible for ensuring the resident's care plan was accurate. The DON said accuracy of care plans was important for continuity of care and so staff were aware what the needs of the residents were. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #4's Admission Record, dated 9/24/24, revealed the was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: Congestive Heart Failure (condition in which the heart can't pump blood well enough to meet the body's needs) , Morbid Obesity (disorder that involves having too much body fat), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Anxiety (feeling of dread, fear, or uneasiness), Insomnia (sleep disorder that makes it difficult to fall asleep or stay asleep), OSA (disorder that occurs when the upper airway partially/completely collapses leading to reduced/absent breathing during sleep), and Lymphedema (swelling in the extremities caused by a lymphatic blockage). Record review of Resident #4's Care Plan, dated 3/14/24 and revised 7/17/24, revealed: [Resident #4] has a terminal prognosis r/t Chronic Systolic (Congestive) Heart Failure Hospice Record review of Resident #4's quarterly MDS assessment, dated 7/29/24, revealed Resident #4 had a BIMS score of 15, suggesting intact cognition. Record review of Resident #4's Medicaid Hospice Program Individual Election/Cancellation/Update, signed by Resident #4 on 9/5/24, revealed: Terminal diagnoses of Chronic Systolic Heart Failure, Lymphedema, and Depression, Pt wishes to seek aggressive treatment. Record review of Resident #4's Baseline Care Plan, dated 9/19/24, revealed Resident #2 did not require terminal care. Attempted interview on 9/25/24 at 11:58 AM to the Hospice A nurse was unsuccessful. During an interview on 9/25/24 at 12:50 PM, LVN E said Resident #4's diuretics were discontinued prior to the hospitalization on [DATE] and should have been resolved on her care plan. LVN E said Resident #4 was not receiving hospice services anymore because the resident revoked the services before going to the hospital on 9/6/24 in order to receive extensive therapy at the hospital. LVN E further stated Resident #4 was not readmitted to hospice upon her return from the hospital. LVN E said she did not know how she missed that Resident #4's care plan still had hospice services included and was not sure what happened. During an interview on 9/25/24 at 3:45 pm, the DON said Resident #4 was not receiving hospice services, adding Resident #4 completed a hospice revocation form on 9/5/24. The DON further stated LVN E must have updated Resident #4's care plan when she saw the discharge order. Record review of Resident #4's Care Plan, dated 3/14/24 and revised 7/15/24, revealed: [Resident #4] is on diuretic therapy r/t edema, fluid retention . Record review of Resident #4's Order Summary revealed: .Bumex Oral Tablet 2 MG .for edema . Discontinued .Order Date 04/15/2024 .Bumex Oral Tablet 2 MG .for edema .Discontinued .Order Date 07/14/2024 .Furosemide Oral Tablet 40 MG .for DIURETICS .Discontinued .Order Date 03/13/24 During an observation and interview on 9/24/24 at 1:15 PM, Resident #4 was sitting in her wheelchair, she said she was on hospice but terminated the services because she wanted to go to the hospital for rehabilitation. Resident #4 said she was not receiving a diuretic at the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/24 at 12:50 PM, LVN E said when Resident #4 was readmitted to the facility she reinstated the care plan that she previously had. LVN E further stated she ran daily reports for medications and changes in condition, so the discontinued medication should have been caught, adding an audit should be done with each MDS assessment. LVN E said the expectation was care plans be updated as necessary after each daily audit (or 72-hour audit following the weekends). LVN E said it was her responsibly, as the MDS nurse, to ensure the accuracy of care plans. During an interview on 9/25/24 at 1:49 PM, MA B said she had not administered a diuretic to Resident #4 during her shift since her return from the hospital. MA B further stated Resident #4 refused the diuretic because it made her urinate too much and she did not like that. During an interview on 9/25/24 at 3:45 PM, the DON said Resident #4 was currently not on a diuretic. The DON further stated Resident #4's care plan did reflect she received diuretic therapy. The DON said the expectation was for the diuretic therapy to be removed from the care plan within I'm guessing 72 hours after it was discontinued. The DON said she did not have a timeline for care plans to be updated. The DON further stated she did not know why Resident #4's care plan was not updated. The DON said LVN E was responsible for auditing the care plans for accuracy. The DON further stated she audited resident records on a weekly basis but focused on different areas, such as weights and falls. the DON said LVN E was responsible for ensuring care plans were accurate, but she took responsibility. The DON further stated it was important that care plans were correct because other staff could see the information and so ensuring they were kept accurate was important. During an interview on 9/25/24 at 5:17 PM, the Administrator said bedrails were supposed to be included in resident care plans and nursing management was responsible for ensuring this. The Administrator further stated CPAPs should be included in resident care plans and her expectation was care plans were updated within 7 days of a change. The Administrator said LVN E was responsible for ensuring the accuracy of resident care plans. Record review of the facility's policy, titled Care Plans, Comprehensive, revised 3/1/2022, revealed: .An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident . 5. Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly and any significant change in status

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices for 1 of 4 residents (Resident #1) reviewed for quality of care/treatment, in that: The facility failed to obtain device orders for Resident #1 on (2) occasions. These failures could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #1's Admission Record, dated 9/24/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Cellulitis (common bacterial skin infection), Hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone), Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Obstructive Sleep Apnea (disorder that occurs when the upper airway partially /completely collapses leading to reduced/absent breathing during sleep), Hypertension (high blood pressure) and Atrial Fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow). Record review of Resident #1's Physical Device Consent and Acknowledgement, dated 9/5/24, revealed the resident signed consent for 1/4 bilateral side rails for generalized weakness and to improve mobility during transfers and repositioning. Record review of Resident #1's Side Rail/Mobility/Positioning Bar Assessment, dated 9/6/24 and authored by RN A, revealed the resident requested the use of 1/4 rails for general weakness or impaired mobility. Further review of this document revealed the resident was observed using the device on 9/5/24. The physician and DON were notified, and the intervention was care planned. Record review of Resident #1's comprehensive MDS assessment, dated 9/9/24, revealed the Resident #1 had a BIMS score of 15, suggesting intact cognition. Record review of Resident #1's Care Plan, dated 9/6/24, revealed the document did not include the use of a bedrails or CPAP. Record review of Resident #1's Order Summary revealed the resident did not have orders for bedrails or CPAP. Record review of Resident #1's Progress Note, dated 9/5/24 and authored by LVN B, revealed: .Resident is bedbound at this time and is able help turn. 1/4 rails on bed to assist resident in repositioning (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Order Summary, dated 9/24/24, revealed the resident did not have an order for bedrails or CPAP. During an observation and interview on 9/24/24 at 12:58 PM, Resident #1 was lying in bed, cleaned/groomed, with no visible injuries. 1/4 rails were observed on the bed as well as a CPAP on the side table. Resident #1 said he had a CPAP. Resident #1 said he used the bed rails to help the staff with repositioning. During an interview on 9/25/24 at 1:54 PM, Resident #1 said he brought the CPAP from home, used it every night and applied it himself because the nurses refused to assist him due to not having an order. Resident #1's family member said she brought the CPAP to the facility when he was admitted but did not remember when that was. Resident #1's family member further stated he had been using the CPAP for at least [AGE] years. During an interview on 9/25/24 at 12:50 PM, LVN E said Resident #1's assessment for bedrails was completed on 9/5/24. LVN E further stated Resident #1 did not have an order for bedrails. LVN E said it was important the physician was contacted for an order for bedrails to ensure bedrails were appropriate for the resident. LVN E said the bedrails were a device Resident #1 consented to and were utilized for bed mobility and increased independence. LVN further stated that due to Resident #1 no having an order for the bedrails, staff may think that this intervention was not correct and remove them, limiting his independence and bed mobility. LVN E said Resident #1 did have a diagnosis of OSA, but the resident did not have an order for a CPAP. LVN E further stated if a CPAP was brought from home for Resident #1 the facility was responsible for contacting the physician to see if this is a treatment he wanted to implement at the facility. LVN E said she believed the charge nurses were responsible for entering orders for the residents. LVN E further stated obtaining orders was important because resident could receive treatment that were not beneficial or could potentially harm them. During an interview on 9/25/24 at 2:04 pm, LVN A said she did not work overnight, but knew that Resident #1 did have a CPAP which he used every night. LVN A said she had not seen the order for a CPAP for Resident #1 but was knew he had orders to wear it overnight because an order was required for CPAP. LVN A said the nurse that admitted Resident #1 was responsible for ensuring the resident had an order for a CPAP or call the physician to obtain an order. LVN A further stated it was important to obtain orders to ensure it was approved by the physician, they had the proper settings, and the resident was wearing it correctly. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 2:58 pm, LVN B said Resident #1 was admitted to the facility on [DATE] and she had the resident sign the consent for the bedrails to assist with repositioning. LVN B further stated she did not remember if she added an order for the bedrails when Resident #1 was admitted . LVN B said an order was required if a resident used bed rails. LVN B further stated an order was needed to verify the bedrails were being used as an assistive device and not a restraint. LVN B said she was not aware that Resident #1 didn't not have an order for bedrails, and she did not have time to review the records for accuracy. LVN B said Resident #1 did not have a CPAP when he was admitted but his family member brought it to the facility the next day. LVN B further stated she refused to assist Resident #1 apply the CPAP when he asked for help because he didn't have an order. LVN B said she messaged the physician a couple days later in regard to the CPAP and had not received a response. LVN B further stated she did not remember if the physician responded to her message or not, adding she deleted all messages to the physician. LVN B said she did not actually call the physician for follow-up. LVN B said she was responsible for orders, as well as other nurses that provide care to Resident #1. LVN B further stated the nurses that audit the charts, sometimes the DON or the ADON were also responsible for ensuring residents had the required orders B said it was important that Resident #1 had an order for the CPAP because it was considered a treatment and they had to make sure he could breathe adequately, are getting the oxygen that they need, are not having difficulties, and the pressure settings were correct. LVN B further stated the facility did not have a way of verifying if Resident #1's CPAP settings were correct because he did not have an order. LVN B said not having an order for the CPAP may affect Resident #1 negatively because he may be dependent on the CPAP to help him rest. LVN B further stated she was not sure what the indications were because there were no orders, he may have apnea, which means he stops breathing at night and may wake up gasping for air which affected his sleep/rest and possible also affected activities due to lack of rest. LVN B said she did miss stuff because she was overworked at times. Attempted telephone interview on 9/25/24 at 3:40 pm with the ADON was unsuccessful. During an interview on 9/25/24 at 3:45 pm, the DON said Resident #1 did have bedrails and a diagnosis of OSA but did not have an order for bedrails or CPAP. The DON further stated she did not know why Resident #1 did not have an order for bedrails. The DON said she did not believe not having orders for the bedrails could result in a negative outcome because the facility obtained a consent from Resident #1 and just did not document for medical record purposes. The DON said she did not know if Resident #1 had a CPAP and had not seen it in his room. The DON further stated Resident #1 did have a diagnosis of OSA and she guessed this was why the family member brought in the CPAP. The DON said she was told by LVN B that Resident #1's family member had brought his CPAP, but she didn't know he had it. The DON further stated Resident #1 did not have an order for a CPAP and that if it were in his room, Resident #1 would have orders. The DON further stated she had never seen Resident #1 with a CPAP or seen it in his room. The DON said the admitting nurse was responsible for ensuring residents had the proper equipment orders. The DON said she was responsible for ensuring resident orders were accurate to ensure the admission process was completed and the ADON was responsible for auditing orders. The DON further stated this was important for continuity of care and so that staff were aware what the resident needs were.

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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** 39251 Based on observation, interview, 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, the comprehensive person-centered care plan, the residents' goals, and preferences for 2 of 4 (Resident #1 and Resident #2) reviewed for respiratory care. 1. The facility failed to ensure Resident #1 was assessed for the use of a CPAP to obtain orders. 2. The facility failed to ensure Resident #2 received CPAP treatments at bedtime or while sleeping per physician orders. These failures could place residents who receive CPAP treatments at risk of no receiving the full therapeutic treatments. Findings included: 1. Record review of Resident #1's Admission Record, dated 9/24/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Cellulitis (common bacterial skin infection), Hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone), Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Obstructive Sleep Apnea (disorder that occurs when the upper airway partially /completely collapses leading to reduced/absent breathing during sleep), Hypertension (high blood pressure) and Atrial Fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow). Record review of Resident #1's comprehensive MDS assessment, dated 9/9/24, revealed the Resident #1 had a BIMS score of 15, suggesting intact cognition. The MDS did not include the diagnosis of OSA or need for CPAP. Record review of Resident #1's Care Plan, dated 9/6/24, revealed the document did not include the diagnosis of OSA or need for a CPAP. Record review of Resident #1's Order Summary, dated 9/24/24, revealed the resident did not have an order for a CPAP. During an observation and interview on 9/24/24 at 12:58 PM, Resident #1 was lying in bed and a CPAP was observed on the side table. Resident #1 said he had a CPAP. During an interview on 9/25/24 at 12:50 PM, LVN E said Resident #1 had a diagnosis of OSA, but this diagnosis/CPAP were not included in the care plan. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 1:54 PM, Resident #1 said he brought the CPAP from home, used it every night and applied it himself because the nurses refused to assist him due to not having an order. Resident #1's family member said she brought the CPAP to the facility when he was admitted but did not remember when that was. Resident #1's family member further stated he had been using the CPAP for at least [AGE] years. During an interview on 9/25/24 at 2:04 PM, LVN A said she did not work overnight, but knew Resident #1 did have a CPAP which he used every night. During an interview on 9/25/24 at 2:58 PM, LVN B said Resident #1 did not have a CPAP when he was admitted but his family member brought it to the facility the next day. During an interview on 9/25/24 at 3:45 PM, the DON said she did not know if Resident #1 had a CPAP and had not seen it in his room. The DON said CPAPs were usually included in the resident care plan. The DON stated Resident #1 had a diagnosis of OSA and she guessed this was why the family member brought in the CPAP. The DON said she was told by LVN B that Resident #1's family member brought his CPAP, but she didn't know he had it. 2. Record review of Resident #2's Admission Record, dated 9/24/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Pulmonary Fibrosis (scarring in the lungs making it difficult to breathe), Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Hyperlipidemia (high levels of fat in the blood), Dementia (group of thinking and social symptoms that interferes with daily functioning) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Hemiplegia (paralysis of one side of the body), Pulmonary Hypertension (high blood pressure affecting the arteries of the lungs and heart), Atrial Fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow), Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and Emphysema (lung disease causing shortness of breath, coughing, and fatigue). Record review of Resident #2's Care Plan revealed the following: [Resident] has altered respiratory status/Difficulty Breathing .has a terminal prognosis r/t pulmonary fibrosis . Resident #2's Care Plan revealed the document did not include the use of a CPAP. Record review of Resident #2's comprehensive MDS assessment, dated 6/14/24, revealed Resident #2's had a BIMS score of 14, suggesting intact cognition. Further review of the MDS revealed Resident #2 had a diagnosis of chronic lung disease and listed Pulmonary Fibrosis as an active diagnosis. Record review of Resident #2's Order Summary revealed: .C-pap, apply at bedtime or when sleeping .order date 9/10/24 During an observation and interview on 9/24/24 at 1:04 PM, Resident #2 was lying in bed, cleaned/groomed, with no visible injuries, the CPAP was on the side table. Resident #2 said she had a CPAP, but it was missing pieces and was not using it. During an interview on 9/25/24 at 12:50 PM, LVN E said Resident #2 had an order for a CPAP but did not see it in her care plan. LVN E further stated she did not know why the CPAP was not included in Resident #2's care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676406	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trucare Living Centers - Selma	16550 Retama Parkway Selma, TX 78154

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 3:45 PM, the DON said Resident #2 had a CPAP but was not sure how it got out because it was missing pieces and she had put it away. The DON further stated Resident #2 had never used the CPAP and she did not have an order for it. The DON said Resident #2's care plan did not include a CPAP because the resident did not have an order for CPAP. Facility policy regarding physician orders for medications/treatments was requested on 9/25/24 at 3:45 pm. The facility provided a policy titled Physician Medication Orders, which did not address physician orders for treatments/devices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to provide pharmacological services to meet the needs of each resident for 1 of 4 residents (Resident #4) reviewed for pharmacy services. The facility failed to obtain medication orders for Resident #4. These failures could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #4's Admission Record, dated 9/24/24, revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Congestive Heart Failure (condition in which the heart can't pump blood well enough to meet the body's needs) , Morbid Obesity (disorder that involves having too much body fat), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Anxiety (feeling of dread, fear, or uneasiness), Insomnia (sleep disorder that makes it difficult to fall asleep or stay asleep), OSA (disorder that occurs when the upper airway partially/completely collapses leading to reduced/absent breathing during sleep), and Lymphedema (swelling in the extremities caused by a lymphatic blockage). Record review of Resident #4's quarterly MDS assessment, dated 7/29/24, revealed Resident #4 had a BIMS score of 15, suggesting intact cognition. Record review of Resident #4's Physician Note, dated 9/19/24 and authored by the FNP, revealed: .CHF: cont. Bumex . Record review of Resident #4's hospital record, dated 9/17/24, revealed: .Furosemide (Lasix) 40 MG .CHF . Lasix started . Record review of Resident #4's Discharge Reconciliation Report, dated 9/19/24, revealed: Furosemide (Lasix) 40 MG by mouth Daily . Record Review of Resident #4's EMR revealed she was not receiving any diuretics (neither Lasix nor Bumex). During an observation and interview on 9/24/24 at 1:15 pm, Resident #4 said she received a copy of medications she received at the hospital and Lasix was listed on it and gave the facility a copy, but she did not receive a diuretic at the facility. Resident #4 provided the state investigator a copy of the Discharge Reconciliation Report from the hospital dated 9/19/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 2:19 pm, LVN C said she did see a diuretic on Resident#4's medication list from the hospital, but the FNP did not check of the medication to add to Resident #4's orders. LVN C further stated she entered orders for the medications that were checked off by the FNP on 9/19/24. LVN C said she had not reviewed the FNP's progress note on 9/19/24. LVN C said it was important that orders were accurate so that medications appear on the MAR and the MA knows to administer the medications ordered. During an interview on 9/25/24 at 3:35 pm, the DON said Resident #4 was not on a diuretic, adding the only thing she thought of was that it was not on the medication reconciliation from the hospital on 9/19/24. The DON further stated she did not know why the FNP added Bumex in her note if it was not on the medication reconciliation. The DON said it was important that orders were accurate because other staff saw this information. The DON said she did not believe that not having an order for the diuretic could result in a negative outcome for Resident #4 because it was not on the MAR and had not been administered. Audits - for orders and care plans, usually the ADON. Attempted telephone interview on 9/25/24 at 12:00 pm with the NP was unsuccessful. Attempted telephone interview on 9/25/24 at 12:01 pm with the MD was unsuccessful. Attempted telephone interview on 9/25/24 at 3:40 pm with the ADON was unsuccessful. Attempted telephone interview on 9/25/24 at 4:30 pm with RN A was unsuccessful. During an interview on 9/25/24 at 5:17 pm, the Administrator said orders were required for bedrails and CPAPs. The Administrator further stated if a resident brought a CPAP from home an order was still required to ensure the resident is using the device correctly. The Administrator said if the resident did not have an order, the facility could not provide the treatment and the physician should have been called for clarification. The Administrator further stated the admitting nurse or the nurse caring for the resident was responsible for obtaining the orders. The Administrator said the nurse management team were responsible for ensuring the accuracy of resident orders. The Administrator further stated if there was not an order for specific medications/treatments the facility may not be aware of the residents' needs. Facility policy regarding physician orders for medications/treatments was requested on 9/25/24 at 3:45 pm. The facility provided a policy titled Physician Medication Orders, which did not address physician orders for treatments/devices.