STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676408	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Creek Nursing and Rehabilitation	3729 Ira E Woods Avenue Grapevine, TX 76051

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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 - Few	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** 41781 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment that describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 16 residents (Resident #5) reviewed for care plan accuracy. The facility failed to develop and implement a care plan for Resident #5, which addressed her use of an anti-depressant medication, Sertraline. This failure placed residents at risk of not receiving needed services due to inaccurate comprehensive care plans. Findings included: Record review of Resident #5's Admission Record, dated 03/19/25, reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (the loss of cognitive functioning that interferes with daily life and activities) and major depressive disorder (a mental disorder characterized by a persistent low mood, loss of interest or pleasure in activities, and a range of emotional and physical problems). Record review of Resident #5's None of the Above MDS Assessment, dated 02/28/25, reflected she had a BIMS score of 03, indicating severe cognitive impairment. It also indicated she was being administered an antidepressant. It did not address her active diagnoses. Record review of Resident #5's Order Summary Report, dated 03/19/25, reflected the following orders: - Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth in the morning for Depression (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 - Few	- Depression: Monitor for depressive symptomology, cyclical and rapid mood shifts (tearfulness, sadness, hopelessness, loss of interest or pleasure, weight loss/gain, reduced/increased appetite, worthlessness, guilt, concentration and/or sleeping difficulties, thoughts of being better off dead, suicidal ideations, etc.)? every shift Enter [sic] progress note describing behaviors observed if applicable. Record review of Resident #5's March 2025 MAR reflected she received Sertraline each day as ordered and had no adverse effects from being monitored for the medication. Record review of Resident #5's care plan, initiated 01/30/25, reflected it did not address her use of the antidepressant, Sertraline. Observation on 03/18/25 at 12:30 PM of Resident #5 revealed she was sitting in the dining room at a table with others. Resident #5 was eating her lunch and appeared dressed and groomed. Resident #5 was not able to answer any of the surveyor's questions based on her condition. Interview on 03/19/25 at 1:25 PM with RN D revealed he cared for Resident #5. RN D said Resident #5 was prescribed the antidepressant Sertraline and was receiving it as far as he knew, but she was not having any adverse effects from it. Interview on 03/20/25 at 1:17 PM with the MDS Coordinator revealed she was responsible for ensuring care plans were completed and accurate. The MDS Coordinator said Resident #5's use of an antidepressant should be addressed on her care plan. The MDS Coordinator said the purpose of that was so that staff could implement all things related to her care, such as her medications she received. The MDS Coordinator said if Resident #5's care plan did not address her use of the antidepressant staff might not know what her care goals were. The MDS Coordinator said she had been previously trained to ensure resident's care plans were complete and accurate. Interview on 03/20/25 at 3:08 PM with the DON revealed Resident #5's use of an antidepressant should have been care planned. The DON said the MDS Coordinator would have been responsible for ensuring Resident #5's care plan was complete and accurate. Record review of the facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022, reflected: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .e. reflects currently recognized standards of practice for problem areas and conditions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43791 Based on observations, interviews, and record reviews the facility failed to ensure the residents environment remained free of accident hazards as possible for 4 of 20 residents (Residents #6, #8, #23, and #47) reviewed for accidents and safety. The facility failed to maintain the sharps containers, which are used to store used syringes and lancets, in a safe manner to prevent the containers from being overfilled and creating a safety hazard in the rooms of Residents #6, #8, #23, and #47. This failure could place residents at risk of exposure to bloodborne pathogens. Findings included: Observation on 03/18/25 at 10:04 AM revealed the sharps container, located in the bathroom for Residents #8 and #23, was filled past the fill line. The flap for depositing sharps in the container was inoperable. Observation on 03/18/25 at 12:33 PM revealed the sharps container, located in the bathroom for Residents #6 and #47, was filled past the fill line, up to the flap for depositing sharps rendering the flap inoperable. There were two used lancets placed on top of the flap. Observation on 03/19/25 at 3:30 PM reflected the sharps containers in Residents #8 and #23 room remained unchanged. A third lancet had been placed on the flap for Residents #6 and #47's sharps container. Interview on 03/19/25 at 3:40 PM with RN C revealed he did not know who was responsible for changing out sharps containers when they were full. He stated the sharps containers were rarely used. He stated the risk of having an overfilled container was exposure to used needles and infections. Interview on 03/19/25 at 3:44 PM with the ADON revealed she did not know who was responsible for changing out the sharps containers. She thought it should be a nursing duty, possibly a housekeeping duty. She stated the lancets placed on top of the flap for Resident #6 and #47 indicated someone had intentionally ignored safety protocols by leaving them exposed instead of changing out the container or at least placing them in a functioning container. The ADON stated over filled sharps containers placed residents at risk of exposure to bloodborne pathogens from used needles. Interview on 03/19/25 at 3:50 PM with the DON revealed she did not know who was responsible for changing out sharps containers. She thought either nursing staff or housekeeping staff should change them out. She stated she did not think there was a policy in place to address sharps containers. She stated the risk to residents was exposure to bloodborne pathogens. Record review of the facility's Sharps Disposal policy, dated January 2012, reflected: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.3. c. Designated individuals will be responsible for sealing and replacing containers when they are 75-80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure residents who are fed by enteral means, received the appropriate treatment and services to prevent complications of enteral feeding, for 1 of 1 resident (Resident #179) reviewed for enteral nutrition. The facility failed to follow physician orders for Resident 179's enteral feeding tube to be flushed with 55 ml of water every 1 hour. This failure could place residents who had gastrostomy tube at risk for fluid deficit. Findings included: Record review of Resident #179's Admission MDS assessment dated [DATE], reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses that included gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach) and dysphasia (swallowing difficulties). Resident #179's BIMS score was 09 revealing moderate cognition. The MDS further revealed Section K (Nutritional approaches) indicated the resident's nutritional approach was a feeding tube. Record review of Resident #179's care plan dated 03/14/25 reflected: Focus: Resident#179 at risk for nutritional deficit rule out NPO/enteral tube feeding. Goal: Will maintain adequate nutrition by enteral feeding through next review date. Interventions: Administer enteral feeding/water flushes as ordered by physician. Record review of Resident #179's physician orders, dated 03/13/25, reflected an order for Enteral Feed Order flush feeding tube with 55 cc of water every 1 hour and with 30 cc of water before and after medication administration. Observation and interview on 03/18/2025 at 11:05 AM revealed Resident #179 lying in bed. Resident #179 was connected to her feeding pump, and the feeding rate was set at 70 mL/hr, and the water flush rate was set at 100 ml every 4 hours. The formula bag was dated 03/18/25 at a rate 70 mL/hr. The water bag was dated 03/18/25. Observation and interview on 03/19/25 at 12:44 PM with LVN A, who was the charge nurse for Resident #179, revealed Resident #179 was connected to her feeding pump. The feeding rate was set at 70 mL/hr, and the water flush rate was set at 100 mL every 4 hours. She stated she was aware the physician order for the flush was supposed to be 55 mL/hr. She stated when she came in the morning, she only checked to ensure the feeding was flowing. She stated she did not check the settings. She stated she knew she was supposed to check the settings, but she forgot. LVN A stated Resident #179 had a g-tube, and the night shift had hung a new formula and water bag. She stated failure to follow the physician orders could lead to dehydration. LVN A stated she had done training on gastronomy tubes regarding medication and feeding administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An phone interview was attempted on 03/20/25 at 10:57 AM with RN B, who was the night nurse, but the attempt was not successful. She did not pick her phone; a voicemail was left. Interview on 03/20/25 at 11:58 AM with the ADON revealed she was not aware Resident #179's water flushes were not set on the pump as per the doctor's orders. She stated she was made aware Resident #179's feeding pump was not accurate on 03/19/25 in the morning by LVN A. She stated she reviewed the orders and Resident #179 was supposed to be on flushes at a rate of 55 mL/hr. She stated, it was expected for the nurses to follow physician orders, and if they had questioned the nurses should notify the doctor and dietician. She stated it was her and the DON's responsibility to monitor nurse and ensure the pumps were set with the correct orders. She stated she had been to Resident #179's room, and she did not check the settings, she only checked whether it was flowing. She stated the potential risk would be dehydration. She stated she had done training on g tube medication and feeding administration. Interview on 03/20/25 at 1:25 PM with the DON revealed she expected the nurses to follow physician and dietitian orders. The DON stated she also expected the nurses to set feeding pumps per the orders. The DON said the person responsible to ensure orders were followed, were nursing staff and nursing management. The DON said that she was responsible to ensure orders were followed by nursing staff through audits. The DON said she had not gone to the resident's room for auditing whether she was set as per the orders. She stated failure to follow the physician orders could lead to dehydration. She stated she had not done training with staff because she was new to the facility. A phone interview was attempted on 03/20/25 03:12 PM with the Dietitian, but the attempt was not successful. Record review of the facility's training records for enteral tube feeding via continuous pump, dated November 2024, reflected a competency assessment for and RN B was in attendance, but LVN A was not in attendance. Record review of the facility's Enteral tube feeding via continuous pump policy, dated November 2018, reflected: 1.Verify that there is a physician order for this procedure. .3.Check the enteral nutrition label against the order before administration. Check the following information . g. Rate of administration (ml/hour) .

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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** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 residents (Resident #55) reviewed for medication administration. The facility failed to ensure that MA H administered Resident #55's Lidoderm Patch 5% (Lidocaine); not a Lidocaine 4% patch. This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings included: Record review of Resident #55's comprehensive MDS assessment dated [DATE] reflected the resident admitted to the facility on [DATE] and a readmission on 11/28/24. He had a BIMS score of 05, which indicated Resident #55's cognition was severely impaired. The MDS reflected Resident #55 required a scheduled pain medication regimen. Record review of Resident 55's care plan dated 08/12/24 reflected, focus Resident #55 needs pain management and monitoring related to: fracture, osteoarthritis (degenerative joint disease where the cartilage that cushions the ends of bones gradually wears away, leading to pain, stiffness, and reduced mobility), contusion of scalp, fall, acute pain due to trauma. goal: Will maintain adequate level of comfort as evidenced by no sing and symptoms of unrelieved pain or distress, or verbalizing satisfaction with level of comfort. Intervention Administer Pain medication as ordered. Record review of Resident #55's physician orders reflected an order dated 10/31/2024 for Lidocaine Patch 5 %. Apply to per additional directions topically in the morning for neck pain apply to posterior neck daily. Observation on 03/19/25 at 7:03 AM revealed MA H preparing morning medications for Resident #55. He explained the procedure to Resident #55, sanitized his hands, and prepared the lidocaine 4% patch. He opened the patch and dated it 03/19/25. He washed his hands, put on gloves, and applied the lidocaine patch on the resident's posterior neck. He removed his gloves and washed his hands. Interview on 03/19/25 at 12:55 PM with MA H revealed he had been applying lidocaine 4% for last 2 days since he was out of 5% for Residents #55. MA H stated he ordered refill for 5% but he could not recall notifying the nurse. He stated he knew he was supposed to let the charge nurse know when orders are not refilled so that he can follow up with pharmacy or call the doctor to get an order for facility to use lidocaine 4% .He stated he was aware he was supposed to have an order to administer lidocaine 4%.The facility had orders for 5%. MA H stated the risk to residents was medication not being effective for him getting a lower dose. He stated he had done an in-service on medication administration and the 5 rights of medication administration; right medication, right dose, right patient, right route, and right time but he could not tell when. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/20/25 at 12:09 PM with the ADON revealed her expectation was if MA H ran out of lidocaine 5%, he should have informed the nurse. She stated an order was made to the pharmacy on 03/19/25, and they received the patches on 03/20/25. She stated she and the DON were responsible for checking the cart and orders, but they did not have a schedule on how to audit the carts because the DON was new. She stated she had checked the carts about one week ago. She stated failure to administer the right dose was the medication would not be effective and could lead to medication error. Interview on 03/20/25 at 1:31 PM with the DON revealed she was not aware Resident #55's lidocaine 5% patches was missing. She stated her expectation was when the MA realized he did not have the right dose, he was supposed to let the nurse know, so that they could have contacted the doctor either to hold or use the 4% lidocaine patch. She stated the risk of not following the orders would be insufficient pain management. She stated she did a one-on-one in-service with MA H when she was notified of the medication error, but she had not done in-services prior because she was new to the facility. Record review of the facility's Administering Medications policy, dated April 2019, reflected: .4.Medications are administered in accordance with prescriber order including any required time . .10.The individual administering the medication checks the label three times to verify the right resident, right medication, right dose, right time, and right method(route) of medication before giving the medication .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 2 of 4 residents (Residents #33 and #99) reviewed for pharmacy services. 1. The facility failed to ensure RN C checked the current physician's orders before administering a PRN Lorazepam (a medication used to treat anxiety) medication to Resident #33 on 03/03/25, who did not have an active order of PRN Lorazepam. 2. The facility failed to ensure RN F administered the correct dosage of PRN Lorazepam (a medication used to treat anxiety) to Resident #99 on 10/31/24 and 11/14/24. These failures could place residents at risk and jeopardize their health and safety. Findings included: 1. Record review of Resident #33's Admission Record, dated 03/19/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #33's Quarterly MDS Assessment, dated 12/13/24, reflected she did not have a BIMS score calculated . Her active diagnoses included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills), anxiety disorder (a group of mental disorders characterized by intense feelings of anxiety and fear), and depression (a mood disorder that causes persistent feelings of sadness and loss of interest). Her MDS also indicated she was receiving hospice services. Record review of Resident #33's care plan, revised on 01/07/25, reflected the following: Focus: Psychotropic medication for Anxiety [sic] .Goal: Resident will feel more peaceful and at ease with improved quality of life through next review .Interventions: Observe the resident closely for significant side effects and report to MD . Record review of Resident #33's Order Summary Report, dated 03/19/25, reflected the following: - Lorazepam Tablet 0.5 mb Give 1 tablet by mouth every 6 hours as needed for Anxiety and agitation for 14 days with an order and start date of 03/06/25. Record review of Resident #33's Electronic Health Record for her discontinued and completed orders reflected she did not have an order for Lorazepam on 03/03/25. Record review of Resident #33's March 2025 MAR reflected there was no indication she received the Lorazepam on 03/03/25. Record review of Resident #33's Progress Notes from 03/03/25 to 03/20/25 did not reflect any information related to her receiving the Lorazepam on 03/03/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #33's Controlled Drug Receipt/Record/Disposition Form reflected the following: - Date Received: 06/24/24; Pt Name: [Resident #33]; Drug Name/Strength: Lorazepam Tab 0.5 MG; Directions: Take 1 tablet by mouth every 6 hours as needed for anxiety/restlessness - Date: 3/3/25 ; Time: [1:20 PM]; Amount Given: 1; Amount Left: 2; Signature: [RN C] Observation on 03/19/25 at 9:57 AM of Resident #33 revealed she was laying in bed resting. Resident #33 did not wake up to the surveyor attempting to ask her questions. Interview on 03/19/25 at 2:44 PM with RN E revealed she normally worked with Resident #33. RN E reviewed Resident #33's Controlled Drug Receipt/Record/Disposition Form for the Lorazepam 0.5 mg and said it was not her signature next to the medication administration on 03/03/25. RN E said she thought it might have been RN C's signature because she asked him to give the medication to Resident #33 one day. RN E said the facility had a low census one day and she and RN C balanced out their residents, so RN C had Resident #33 that day (03/03/25). RN E said Resident #33 was anxious at times and sometimes needed to be administered her PRN Lorazepam medication. Interview on 03/19/25 at 3:11 PM with RN C revealed he reviewed Resident #33's Controlled Drug Receipt/Record/Disposition Form for the Lorazepam 0.5 mg and said it was his signature next the medication administration on 03/03/25. RN C said he and RN E switched residents that day (03/03/25) and he normally did not care for Resident #33. RN C said he was told by RN E to give Resident #33 her PRN Lorazepam medication to address her anxiousness . RN C said after he administered Resident #33 her medication he noticed in her chart that she did not have a current PRN Lorazepam order. RN C said he was not able to document the medication administration on Resident #33's MAR because there was not an active order. RN C said he also did not make a note of the medication administration, nor did he call the doctor or report to the DON at the time. RN C said Resident #33 did not appear to have any adverse effects from the medication that day. RN C said he knew and had been trained that he was always supposed to check a resident's orders prior to administering a medication. Interview on 03/20/25 at 3:08 PM with the DON revealed she was told by RN C and RN E that they had switched rooms and RN C had cared for Resident #33 who he was not as familiar with one day (03/03/25). The DON said RN C should have confirmed the PRN Lorazepam order before he administered it to Resident #33. The DON said she was not sure why he did not check her orders first and she was unaware of it until yesterday (03/19/25) when it was brought to her attention. The DON said once RN C noticed there was no active order, he should have called her doctor to see what the next steps could have been. RN C said as far as she knew, Resident #33 did not have any adverse effects from the medication. The DON said this situation was considered a medication error. 2. Record review of Resident #99's Admission Record, dated 03/18/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and discharged on [DATE]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #99's Quarterly MDS Assessment, dated 10/13/24, reflected she had a BIMS of 08, indicating moderate cognitive impairment. Her diagnoses included non-alzheimer's dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual personal, social, or occupational activities) and secondary malignant neoplasm of unspecified lung (refers to cancer that has spread to the lungs from a primary cancer elsewhere in the body). Record review of Resident #99's Order Summary Report, dated 03/18/25, reflected: - Lorazepam Oral Tablet 0.5 mg (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for Anxiety with a start date of 10/12/24 Record review of Resident #99's October 2024 MAR reflected there was no administration entry noted for 10/31/24 regarding her PRN Lorazepam Oral Tablet 0.5 mg. Record review of Resident #99's Individual Patient's Antibiotic/Narcotic Record reflected the following: Patient: [Resident #99], Medication: Lorazepam 0.5 MG tablet Take 1 tablet PO mouth [sic] every 4 hrs as needed for anxiety Date: 10/31/24; Time: 1000 [10:00 AM]; Amt Given: 2; Amt Remaining: 57; Nurse/Med-Aid Signature: [RN F] Date: 11/14/24; Time: 9:00 [AM]; Amt Given: 2; Amt Remaining: 55; Nurse/Med-Aid Signature: [RN F] Record review of Resident #99's November 2024 MAR reflected RN F had signed off that the resident had received their PRN Lorazepam Oral Tablet 0.5 mg on 11/14/25. Record review of Resident #99's care plan, initiated on 08/08/24, did not reflect her use of PRN Lorazepam. Record review of Resident #99's progress notes from 10/31/24 to 11/15/24 did not reflect any information related to the 10/31/24 PRN Lorazepam administration. Record review of Resident #99's progress notes from 10/15/24 to 11/15/24 reflected the following entries: - 11/14/24 3:02 PM - Lorazepam Oral Tablet 0.5 MG Give 1 tablet by mouth every 4 hours as needed for anxiety. This eMAR - Medication Administration Note was written by RN F. - 11/14/24 3:45 PM - Resident is alert, oriented and talking about prn medication. Her vitals were monitored. Informed her [RP] about prn medication, vitals status and notified to hospice nurse [sic]. Resident is on continue monitoring [sic]. A Nurse's note made by RN G on 11/14/24 at 3:45 PM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2-10 assigned nurse informed the writer that as per [RP], resident was given prn medication without indication. Did assessment for any adverse reactions or health risk. Resident was up and awake, vitals were stable, [RP] was at bedside and aware of the situation. Collaborated with morning and evening staff. Give 1:1 education to the staff to improve and to foster a safer environment for resident. MD and hospice were informed and no new orders received. Will continue to monitor closely for any change in condition. A Nurses note made by the previous DON on 11/14/24 at 3:48 PM Record review of a Record review Discussion Form, created 11/15/24, for RN F reflected the following: Date of Incident: 11/14/24; Date of Conversation: 11/15/24; Description of Incident: [RN F] did not follow PCC orders for patient in room [Resident #99's room]; Supervisor Comments: During an audit it was found that [RN F] did not follow orders listed in PCC for patient in room [Resident #99's room] Failing to perform work assignments whether by supervisor or electronic orders is against company code of conduct. Plan for Improvement: [RN F] must follow all orders in PCC for each patient. Record review of a grievance, dated 11/15/24, filed by Resident #99's RP reflected the following: Describe in detail your concern: Received a voice message on 11/14/24 from [RN G] stating 'hi [Resident #99's RP] I'm evening nurse and Ativan [Lorazepam] was given by morning nurse [sic]'. 'She told me that [Resident #99] was having anxiety and not feeling well so she gave her prn medicine (Ativan) and when I got here I took her vital signs and she's better now.' Failure to notify sister [Resident #99's RP] of the administration of prn Ativan 0.5 mg prior to given (2) tablets of 0.5 mg Ativan to [Resident #99] by [RN F]. Record review of a Medication Error Incident Report, dated 11/14/24, reflected the previous DON completed the report and there were no adverse effects to Resident #99. Interview on the phone on 03/17/25 at 3:50 PM with Resident #99's RP revealed there was a nurse at the facility who administered too much Lorazepam to Resident #99 on 10/31/24 and 11/14/24. Resident #99's RP said she felt this was considered an overdose and was very concerned about Resident #99 afterwards. Attempted phone call to RN F on 03/19/25 at 3:02 PM went unanswered and no call backs were received by time of exit. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/20/25 at 12:59 PM with the ADON revealed she was aware that Resident #99 had received too much medication on 10/31/24 and 11/14/24. The ADON said Resident #99 should have just been given 1 tablet of the Lorazepam as ordered since it was 0.5 MG, but she was administered 2 tablets for a total of 1 MG by RN F on 10/31/24 and 11/14/24. The ADON said RN F should have followed the rights of medications such as making sure the dose was appropriate, it was the right situation and time, and so on. The ADON said she was not sure why RN F chose to administer more than what the doctor ordered since the order was clear to only give 0.5 MG which would have been only 1 tablet. The ADON said those would have been considered medication errors. The ADON said she only recalled hearing about the 11/14/24 medication error because Resident #99's RP was upset about it. The ADON said Resident #99 did not have any adverse effects from the medication administrations on 10/31/24 and 11/14/24 that she knew about. The ADON said she could only assume that RN F administered the medications to Resident #99 because she was showing signs of anxiousness. The ADON said all staff were responsible for ensuring they followed an order if they were administering a medication. The ADON said all staff had been trained on how to administer medications to residents. The ADON said the purpose of administering orders correctly was to ensure the quality of care for the resident. The ADON said the resident could suffer adverse effects if the staff administered too much medication to them. Interview on 03/20/25 at 3:08 PM with the DON revealed she started working at the facility about a month and a half ago and was not at the facility back in October or November 2024. The DON said she looked at Resident #99's controlled substance sheet for her PRN Lorazepam and saw that RN F administered 2 tablets to Resident #99 on 10/31/24 and 11/14/24. The DON said that medication administration did not follow the orders of only giving 1 tablet to Resident #99 on those dates. The DON said she expected all nurses to follow doctor's orders. The DON said the purpose was to ensure the staff were giving correct doses/routes/frequencies to the residents in regards to their medications. The DON said if staff gave more medications to a resident than what was ordered, such as in this case, that could lead to increased lethargy or drowsiness. The DON said since she was not at the facility at the time of these administrations, she was not sure if the resident suffered any adverse effects. The DON said she expected staff to always check the order before they administered a medication, and they had been trained to do so. The DON said periodically, she checked to ensure residents were receiving their medications as ordered. Record review of the facility's policy Administering Medications, revised April 2019, reflected: .4. Medications are administered in accordance with prescriber orders .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Record review of the facility's policy Medication and Treatment Orders , revised July 2016, reflected: 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state .3. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for and 1 of 3 medication carts (Hall 100 and 200 nurse medication carts) reviewed for medication storage. The facility failed to ensure the nurses cart for 100 and 200 halls did not contain insulin, nebulizers, and inhalers that were opened and not labeled with the open date. This failure could place residents at risk of adverse medication reactions. Findings included: Observation on [DATE] at 9:07 AM revealed the nurse's medication cart for 100 and 200 halls with LVN A had the following opened medications with no open date labeled: 1. Lantus insulin pen 2. Symbicort inhaler 3. Azelastine nasal spray 4. 4 boxes Ipratropium Bromide and albuterol sulfate inhalation solution Interview on [DATE] at 12:31 PM with LVN A, she said the nurse that had opened the insulin vial was supposed to put the open date. She also stated once inhalers, nasal spray, and nebulizers are opened they need to be dated with open dates. She said it was the responsibility for all nurses to check carts for labelling and dating every shift, but she did not check the whole cart that morning. She stated insulins are good for 28 days and inhalers are also good for 30 days. She stated the risk of not having an opening date was they would not be able to know when they expire, and they will not be effective. She stated she had not done training on labelling and storage since she was newly hired. Interview on [DATE] at 12:14 PM with the ADON revealed she expected all nurses to check their carts every shift for labelling, dating, and for expired medication. She stated insulins, nasal sprays, inhalers, and nebulizer should be dated with opened dates. She stated insulins vials and pens were good for 28 days and other inhalers, nebulizers, and nasal spray are good depending on manufacturers information. She stated it was her and the DON's responsibility to audit carts, but they have not come up with a schedule since the DON was new. She stated she checked the 100 and 200 halls cart one week ago. She stated the risk of not putting open dates on meds was staff would not know when they expire, and they might not be effective. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 1:36 PM with the DON revealed she said inhalers, insulin, and nasal spray when opened should be dated. She stated it was the responsibility of nursing management to check and audit the carts after the nurses. The DON said the nurses were responsible for dating the medication when opened. She stated insulin was good for 28 days, and the inhalers and nebulizer should be dated once the box was opened. The DON said the facility had in-serviced staff on [DATE] on putting dates on medication when opened and storage for effectiveness. Record review of the facility's in-service record, dated [DATE], regarding the topic of nebulizers, eye drops, inhalers, and insulins needing an open date and being discarded per protoco reflected LVN A was not in attendance. Record review of the Medication Storage and Labeling policy, dated February 2023, reflected the following: 1. Labelling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. .5. Mult-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42859 Based on observations, interviews, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 refrigerators reviewed for infection control. The facility failed to store specimen swabs in the specimen refrigerator, and the specimen was stored in the 100 and 200 refrigerators with medications. This failure could place the residents at risk of exposure to cross contamination and infections. Findings included: Observation on 03/19/25 at 9:48 AM with LVN A of the 100 and 200 halls medication room refrigerator revealed a flu swab specimen wrapped in plastic paper dated 03/11/25 stored with other medications in the refrigerator. Interview on 03/19/25 at 12:34 PM with LVN A revealed she was unaware the swab was stored in the medication refrigerator. She stated the facility had a specimen refrigerator on the 300 and 400 halls medication room, where they put specimen for collection by the laboratory staffs. She stated specimen are separated to prevent contamination. LVN A stated she did an in-service while she was hired that addressed specimen storage. Interview on 03/20/25 at 12:14 PM with the ADON revealed her expectation was when nurses collected specimen, they were to be stored in the biohazard specimen refrigerator. She stated the risk of mixing the specimen and medication was growth of pathogens and could lead to contamination. Interview on 03/20/25 3:58 PM with the DON revealed her expectation was when nurses collected specimen they were stored in the biohazard specimen refrigerator. She stated she was aware the specimen was collected on 03/11/24. She stated they looked for the specimer and could not find it, so they had to collect another sample. She stated she did not know the specimen was stored on the medication refrigerator. She stated the risk of mixing the specimen and medication was that it could lead to cross-contamination. She stated she had not done in-service for staff regarding specimen storage. Record review of the facility's current, undated Separation of Medication and Specimen Storage policy reflected: .Medication and biological specimens must be stored in separate, clearly labeled to indicate its designated use. 1. Designation of refrigerators: a. Assign specific refrigerators exclusively for medications storage and others for specimen storage. Each refrigerator must be clearly labeled to indicate its designated use .

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. 43791 Based on observations, interviews, and record reviews the facility failed to ensure resident rooms were equipped to assure full visual privacy for each resident for 4 of 20 residents (Residents #8, #9, #23, and #25) reviewed for privacy. The facility failed to ensure the rooms of Residents #8, #9, #23, and #25 were equipped with privacy curtains to assure full visual privacy. This failure could place the residents at risk of being embarrassed if they were exposed during care. Findings included: Observation and interview on 03/18/25 at 10:04 AM revealed Resident #23's bed had no privacy curtain in place. Curtain rail and clips were present on the ceiling, but no curtain was in place. Resident #23 stated she worried someone could walk in and see her being changed or being bathed. Resident #8 had a privacy curtain that only separated her bed from Resident #23's bed, but did not provide privacy at the end of her bed. Resident #8 was non-verbal. Observation on 03/18/25 at 10:23 AM revealed Resident #9's bed had no privacy curtain. Curtain rail and clips were present on the ceiling, but no curtain was in place Resident #9's bed was located next to the door. Observation and interview on 03/18/25 at 10:27 AM revealed Resident #25 had no privacy curtain. Curtain rail and clips were present on the ceiling, but no curtain was in place. Resident #25's bed was located next to the door. Resident #25 stated it didn't bother him if staff kept the door closed. but he would be embarrassed if someone walked in while he was being changed. Interview on 03/20/25 at 10:10 AM with the Housekeeping Supervisor revealed she worked with maintenance to change out privacy curtains. She stated she had seven curtains in reserve, she would take down seven curtains and replace them with the reserved curtains. She would wash the seven curtains and repeat the process. She changed out curtains once a month, or more often if needed. She stated she had not been made aware there were missing curtains, and she did not have any curtains waiting to be washed. Follow-up observations on 03/20/25 at 10:20 AM revealed the privacy curtains were still not in place for Residents #8, #9, #23, and #25. The surveyor knocked on Resident #8's closed door, received no responsem and entered the room. CNA D was providing incontinence care to Resident #8 leaving the resident exposed. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/20/25 at 10:25 AM with CNA D revealed she knew the privacy curtain was there but did not pull it. She stated she relied on telling anyone entering the room during care that she was providing care, so they did not enter. The surveyor stated he had not heard her say anything about cares being in progress when he knocked on the door. The surveyor advised CNA D he could see Resident #8 exposed. CNA D admitted that would have been prevented if she had pulled the privacy curtain. She stated the privacy curtains were there to provide the resident with privacy and dignity during cares. Interview on 03/20/25 at 10:30 AM with RN E revealed the residents needed their privacy curtains to maintain their privacy and dignity. She stated nurses and CNAs should notify maintenance if they noted missing curtains. She stated she was not aware the curtains for Residents #8, #9, #23, and #25 were missing and did not know how long they had been missing. Interview on 03/20/25 at 10:35 AM with the DON revealed the privacy curtains were in place to maintain resident privacy and dignity. She stated the curtains protected residents if they were exposed and someone walked in the door. She stated anyone noting a missing curtain could notify maintenance to have it replaced. Interview on 03/20/25 at 11:00 AM with the Maintenance Director revealed he was not aware of any privacy curtains needing to be hung up. He stated staff should tell him directly or put a request in for the replacement. Record review of the facility's Dignity policy, dated February 2021, reflected: .11. Staff shall promote. maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. The policy did not address privacy curtains directly.