STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ventana by Buckner	8301 N. Central Expressway Dallas, TX 75201

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interview and record review, the facility failed to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months for one (Resident #36) of six residents reviewed for quarterly assessments. The facility did not ensure Resident #36's Quarterly MDS Assessment, dated 10/28/24, was completed withing 92 days of the previous assessment. These failures could place residents at-risk of not having their assessments completed timely. Findings included: Record review of Resident #36's Face Sheet dated 12/1/7/24 reflected a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #36's EHR reflected her Quarterly MDS Assessment with Assessment Reference Date 10/28/24 was created and submitted on 12/17/24. Resident #36's previous Quarterly MDS Assessment reflected and Assessment Reference Date of 7/25/24 and was completed on 8/5/24. In an interview on 12/17/24 at 1:57 PM, The MDS Nurse stated she realized she had missed Resident #36's Quarterly MDS Assessment and had completed and submitted it that day. She stated the risk of missing MDS assessments was that residents may need an updated care plan and changes in condition could be missed. In an interview on 12/17/24 at 2:05 PM, the DON stated she was told by the MDS Nurse that morning that she had missed Resident #36's Quarterly MDS Assessment which was due in October. She stated she had encouraged her to set up a calendar with reminders of when the assessments were due. The DON stated the MDS Nurse was responsible for timely completion of the assessments. She stated she monitored the Discharge MDS assessments to ensure they were completed but it was the MDS Nurse's responsibility to monitor the others. She stated the risk for missing MDS assessments was changes in the resident's condition could be missed which were important for care planning. Record review of the facility's policy titled, Minimum Data Set (MDS), dated revised 11/26/2024, reflected: Service Standard [company name] will complete accurate resident assessments and submit assessments in accordance with current federal and state submission timeframes .3. Timeframes for completion and submission of assessments is based on current requirements published in the RAI manual .

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676483	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ventana by Buckner	8301 N. Central Expressway Dallas, TX 75201

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interviews and record review, the facility failed to ensure assessments accurately reflected the resident's status for one (Resident #36) of six residents reviewed for accuracy of assessments. The facility failed to ensure that Resident #36's Quarterly MDS Assessment included interviews conducted within the required timeframes. These failures could place residents at risk for not receiving care and services to meet their needs. Findings included: Record review of Resident #36's Face Sheet dated 12/17/24 reflected a [AGE] year-old female admitted to the facility on [DATE] . Record review of Resident #36's EHR reflected her Quarterly MDS Assessment with Assessment Reference Date 10/28/24 was created and submitted on 12/17/24. Record review of Resident #36's Quarterly MDS dated [DATE] reflected, Look back period for all items is 7 days unless another time frame is indicated. MDS Section C reflected a BIMS had been conducted and she had score of 3 indicating severely impaired cognition. Section D reflected a mood interview (PHQ-9) been conducted with a score of 0, indicating none or minimal depression. Her diagnoses included Non-Alzheimer's dementia and depression. Section Z0400 (used to identify who completed each section of the assessment) reflected no entry was made for sections C or D. In an interview on 12/17/24 at 1:57 PM, The MDS Nurse stated she realized she had missed Resident #36's Quarterly MDS Assessment and had completed and submitted it that day. She stated she obtained the information for the assessment from the resident's clinical record. The MDS Nurse stated sections C and D should have had dashes entered because the interviews were not completed during the look back period. She stated she must have entered the information from her previous assessment in error and would submit a correction. She stated accuracy of a MDS assessment was important because, if a change was captured then the resident may need an updated care plan. In an interview on 12/17/24 at 2:05 PM, the DON stated she was told by the MDS Nurse that morning that she had missed Resident #36's Quarterly MDS Assessment which was due in October. The DON stated the MDS Nurse was responsible for timely completion and accuracy of the assessments. She stated she monitored the Discharge MDS assessments to ensure they were completed but it was the MDS Nurse's responsibility to monitor the others. The DON stated she was not aware of the errors made with the BIMS and mood interviews. She stated the risk for inaccurate MDS assessments was changes in the resident's condition could be missed which were important for care planning. (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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1. 19.1 dated October 2024 reflected, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts . In addition, the assessment must represent an accurate picture of the resident's status during the observation period of the MDS .Section C: Cognitive Patterns .Coding Tips Attempt to conduct the interview with ALL residents. The interview is conducted during the look-back period of the Assessment Reference Date (ARD) .If the resident interview was not conducted within the look-back period (preferably the day before or day of the ARD .the standard 'no information' code (a dash '-') entered in the resident interview items .Section D: Mood .Coding Tips Attempt to conduct the interview with ALL residents. The interview is conducted during the look-back period of the Assessment Reference Date (ARD) .If the resident interview was not conducted within the look-back period (preferably the day before or day of the ARD .the standard 'no information' code (a dash '-') entered in the resident interview items . Record review of the facility's policy titled, Minimum Data Set (MDS), dated revised 11/26/2024, reflected: Service Standard [company name] will complete accurate resident assessments and submit assessments in accordance with current federal and state submission timeframes .2. The MDS coordinator will ensure that appropriate edits are made prior to submitting the MDS data.

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NAME OF PROVIDER OR SUPPLIER Ventana by Buckner		STREET ADDRESS, CITY, STATE, ZIP CODE 8301 N. Central Expressway Dallas, TX 75201	

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interview and record review the facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions for one (Resident #67) of 3 residents reviewed for discharge planning. The facility failed to develop and implement a discharge plan for Resident #67 who's goal was to return to the community. This failure could place residents at risk of not receiving care and services to meet their needs upon discharge. Findings included: Record review of Resident #67's Face Sheet dated 12/18/24 reflected he was a [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE]. Record review of Resident #67's Admission MDS assessment dated [DATE] reflected he was cognitively intact, he used a cane for mobility, and he required partial to maximum assistance with ADLs. His diagnoses included urinary tract infection, diabetes, and depression. His overall goal was discharge to the community and active discharge planning was already occurring for the resident to return to the community. Record review of Resident #67's Discharge assessment-return not anticipated MDS dated [DATE] reflected the discharge was unplanned. Record review of Resident #67's Care Plan dated 12/18/24 reflected: Problem-Impaired bed mobility. Goals included: A discharge plan will be developed with [Resident #67] and family/caregivers related to bed mobility needs. Interventions included: Prior to discharge, determine that all necessary durable medical equipment and assistive devices are available and ready for use by [Resident #67]. Utilizing the interdisciplinary team, determine discharge needs such as home health services and/or outpatient therapy. There were no other entries related to discharge planning or goals located within the Care Plan. Record review of Resident #67's physician's orders revealed no order for discharge was located. Record review of Resident #67's physician progress note dated 10/30/24 reflected: Date of Service 10/29/24. History of present illness: .Pt is a 90 yo M who presented to OSH with confusion and found with bronchitis, UTI. Pt started on abx and improved. Remainder of stay was uneventful but OSH records limited on review. Once pt was stable, pt was noted to benefit from continued medical oversight and therapy before dc to home, so pt was transferred to [nursing facility name] for such needs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pt today is in room, I assisted the tech with care. Pt denies pain, feels well. States he is waiting on room to be made upstairs so he can move in by end of week. DON unaware. No other complaints . Record review of resident #67's nursing notes reflected the following entries: Entry dated 10/30/24 4:49 AM: Received resident in room lying in bed with eyes open, sitter at bedside. Resident remains on skilled nursing services for dx: UTI. Alert and oriented x 2-3, respiration even and unlabored, continues on po ABT Amoxicillin 875 mg day 2/3 and Doxycycline 100mg capsule day 2/2 related to UTI with NARN, incontinent of bowel and bladder, incontinent care provided as needed, no s/s of acute distress nor discomfort noted, able to verbalize needs, on cont. 02 2lpm via N/C, safety maintained, bed in comfortable low position, call light within reach, will continue to monitor and update any changes. Entry dated 10/31/24 at 8:03 PM reflected: Pt. discharged to Assisted Living facility today per MD orders patient V/S stable no complaints of pain or discomfort BBS clear BSx4 family RP notified of change medications reviewed and transferred with patient. Record review of Resident #67's EHR revealed no discharge planning documentation was located within his record. During an interview on 12/18/24 at 10:05 AM, the Administrator stated no discharge planning had been completed for Resident #67. She stated the social worker was previously responsible for conducting discharge planning and his was missed because she left . She stated His Discharge MDS reflected an unplanned discharge because he wanted to leave sooner than initially expected. He just said he was ready to go and wanted to leave. She stated she was unsure whether he had any home health needs and would look for any additional documentation. No additional documentation related to discharge planning was provided. During an interview on 12/18/24 at 11:07 AM, the DON stated the social worker was responsible for discharge planning. She stated Resident #67 resided in the facility's Assisted Living unit and returned there after receiving skilled therapy in their unit. She stated she did not believe he required any additional services, and he left on the same level of care he had prior to his admission. The DON stated the risk of not completing discharge planning was residents may be on different medications or treatments that they were not on prior to admission and treatments could be missed. Record review of the facility's policy titled, Discharge Summary dated revised 11/26/24 reflected: The purpose of the discharge summary and the post discharge plan of care with instructions is to assist the resident in adjusting to his/her new living environment by providing continuity of care information. 1. When anticipating a resident's discharge or upon the death of a resident, complete a discharge summary including: . d. a post-discharge plan of care developed with participation of the resident/resident's representative, or legal guardian; and with the resident's consent, the resident's representative, which will assist the resident to adjust to his/her new living environment. This includes where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any post-discharge medical and non-medical services .4. Member(s) of the Interdisciplinary Team will review the Discharge Plan of Care with the resident/resident's representative before the discharge is to take place. 5. A copy of the post-discharge plan of care and summary will be given to the resident and the receiving facility. A copy will be retained in the resident's medical records.

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NAME OF PROVIDER OR SUPPLIER: Ventana by Buckner		STREET ADDRESS, CITY, STATE, ZIP CODE: 8301 N. Central Expressway Dallas, TX 75201	

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interview and record review, the facility failed to ensure residents had a discharge summary that included a recapitulation of the resident's stay, medication reconciliation, and a post-discharge plan of care for one (Resident #67) of 3 residents reviewed for discharge summaries. The facility failed to complete a discharge summary for Resident #67 when he discharged home from the facility. This failure could place residents at risk of a recapitulation of the stay being unavailable to help ensure continuity of care once they went back home. Findings included: Record review of Resident #67's Face Sheet dated 12/18/24 reflected he was a [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE]. Record review of Resident #67's Admission MDS assessment dated [DATE] reflected he was cognitively intact, he used a cane for mobility, and he required partial to maximum assistance with ADLs. His diagnoses included urinary tract infection, diabetes, and depression. His overall goal was discharge to the community and active discharge planning was already occurring for the resident to return to the community. Record review of Resident #67's Discharge assessment-return not anticipated MDS dated [DATE] reflected the discharge was unplanned. Record review of Resident #67's Care Plan dated 12/18/24 reflected: Problem-Impaired bed mobility. Goals included: A discharge plan will be developed with [Resident #67] and family/caregivers related to bed mobility needs. Interventions included: Prior to discharge, determine that all necessary durable medical equipment and assistive devices are available and ready for use by [Resident #67]. Utilizing the interdisciplinary team, determine discharge needs such as home health services and/or outpatient therapy. Record review of Resident #67's physician's orders revealed no order for discharge was located. Record review of Resident #67's physician progress note dated 10/30/24 reflected: Date of Service 10/29/24. History of present illness: .Pt is a 90 yo M who presented to OSH with confusion and found with bronchitis, UTI. Pt started on abx and improved. Remainder of stay was uneventful but OSH records limited on review. Once pt was stable, pt was noted to benefit from continued medical oversight and therapy before dc to home, so pt was transferred to [nursing facility name] for such needs. Pt today is in room, I assisted the tech with care. Pt denies pain, feels well. States he is waiting on room to be made upstairs so he can move in by end of week. DON unaware. No other complaints . No other issues at this time . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #67's nursing notes reflected the following entries: Entry dated 10/30/24 4:49 AM: Received resident in room lying in bed with eyes open, sitter at bedside. Resident remains on skilled nursing services for dx: UTI. Alert and oriented x 2-3, respiration even and unlabored, continues on po ABT Amoxicillin 875 mg day 2/3 and Doxycycline 100mg capsule day 2/2 related to UTI with NARN, incontinent of bowel and bladder, incontinent care provided as needed, no s/s of acute distress nor discomfort noted, able to verbalize needs, on cont. 02, 2 lpm via N/C, safety maintained, bed in comfortable low position, call light within reach, will continue to monitor and update any changes. Entry dated 10/31/24 at 8:03 PM reflected: Pt. discharged to Assisted Living facility today per MD orders patient V/S stable no complaints of pain or discomfort BBS clear BSx4 family RP notified of change medications reviewed and transferred with patient. Record review of Resident #67's EHR revealed no discharge summary documentation was located within his record. Record review of a Clinical Notes Report dated 12/18/24 from Resident #67's Assisted Living facility reflected the following: Entry dated 10/31/24 7:34 PM: Resident transferred back to AL. to [room number] this afternoon alerts and oriented x 4 denies any pain or discomfort resp. even and unlabored no sob, noted no coughing or congestion noted. Resident stated, I am very happy I am returning to my room, and I feel better now. All medications verified with [physician name] and all order updated. Resident [eats] in the dining room and appetite fair encourage by mouth fluids tolerated well. vitals checked stable. will continue to monitor. During an interview on 12/18/24 at 10:05 AM, the Administrator stated no discharge planning had been completed for Resident #67. She stated the social worker was previously responsible for completing discharge summaries and his was missed because she left. She stated His Discharge MDS reflected an unplanned discharge because he wanted to leave sooner than initially expected. He just said he was ready to go and wanted to leave. She stated other staff were assisting with social work duties such as referrals and a new one would be starting the following week. During an interview on 12/18/24 at 11:07 AM, the DON stated no discharge summary was completed for Resident #67 because the Social Worker was responsible for it and she left. She stated resident #67 was returning to his assisted living apartment within the same facility and she believed he left on the same level of care he had prior to his hospitalization and skilled stay. She stated he would have been discharged with his medications and would look for any other documentation that may be available. She stated the risk for failing to complete a discharge summary was they may be on different medications than when previously at home and could possibly miss changes in treatments or equipment needed. om In an interview with the DON on 12/18/24 at 3:37 PM, she stated she had been unable to locate any documentation of a discharge summary other than the clinical note from the assisted living facility indicating his medications had been verified and ordered. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Discharge Summary dated revised 11/26/24 reflected: Service Standard It is the service of [company name] to complete a discharge summary to his/her new living environment. The purpose of the discharge summary and the post discharge plan of care with instructions is to assist the resident in adjusting to his/her new living environment by providing continuity of care information. 1. When anticipating a resident's discharge or upon the death of a resident, complete a discharge summary including: a. A recapitulation of the resident's stay that includes, but is not limited to diagnose, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. b. A final summary of the resident's stay at the time of discharge. c. Reconciliation of all pre-discharge medications with the resident's post discharge medications (both prescribed and over the counter) d. a post-discharge plan of care developed with participation of the resident/resident's representative, or legal guardian; and with the resident's consent, the resident's representative, which will assist the resident to adjust to his/her new living environment. This includes where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any post-discharge medical and non-medical services. 2. Information for a receiving facility must include, but are not limited to the resident's: a. Contact information for the resident's medical provider; b. Resident's representative information including contact information; c. Advance Directive information; d. All special instructions of precautions for ongoing care, as appropriate; e. Comprehensive care plan goals; f. All other necessary information, including a copy of the resident's discharge summary .

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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 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37193

Based on observation, interview, and record review the facility failed to ensure its medication error rates were not 5% or greater. The facility had a medication error rate of 23% based on 10 errors out of 43 opportunities which involved 1 of 4 residents (Resident #32) and 1 of 3 staff (LVN A) reviewed for medication error, in that:

LVN A crushed medication and mixed all the fourteen (14) medications together and administered through a gastrostomy tube (surgically placed to provide direct access to a human's stomach for supplemental feeding, hydration, or medication) to Resident #32

These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health.

Findings included:

Record review of Resident #32's face sheet dated 12/18/24 revealed an [AGE] year-old male who admitted on [DATE]. his diagnoses included pneumonitis (general term that refers to swelling and irritation, also called inflammation, of lung tissue)due to inhalation of food and vomit, hypertension pain, constipation, muscle spasm, gastro-esophageal reflux disease without esophagitis (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus.), muscle weakness, muscle wasting, lack of coordination, difficulty in walking, anxiety disorder and gastrostomy status,

Record review of Resident#32's quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 out of 15, which indicated severe cognitive impairment. He required assistance from staff with ADL care.

Record review of Resident #32's care plan dated 12/28/24 revealed Resident #32 receiving tube feedings, with goal for Resident #32 to receive adequate nutrition without side effects associated with tube feedings (aspiration, diarrhea, dehydration)

Record review of resident #32's physician orders for December 2024 revealed orders for:

Ferrous sulfate 300 mg (60 mg iron)/5 ml oral liquid (5ml) liquid (ml) g-tube, lactobacillus acidoph-l. bulgaricus 1 million cell tablet (1) tablet g-tube, aspirin childrens 81 mg chewable tablet (1) tablet, chewable g-tube, fexofenadine 180 mg tablet (1) tablet g-tube, gabapentin 400 mg capsule (1) capsule g-tube, magnesium 400 mg (as magnesium oxide) capsule (1) capsule g-tube, melatonin 5 mg tablet (1) tablet g-tube, metoprolol tartrate 50 mg tablet (1) tablet g-tube, glycopyrrolate 1 mg tablet (1 tablet) tablet g-tube, escitalopram 5 mg tablet (1) tablet g-tube, cefdinir 300 mg capsule (1) capsule g-tube, doxycycline hyclate 100 mg capsule (1 cap) capsule g-tube, nexium 40 mg capsule, delayed release (1 packet) capsule, delayed release (enteric coated) g-tube and flush enteral feeding tube with 15ml of tap water before & after each individual medication administration per g-tube.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 12/17/24 at 09:20 AM revealed LVN A administering the following medication to Resident #32 though the g-tube; Aspirin 81 mg chewable, cefdinir 300 mg capsule, doxycycline hyclate 100 mg , esomeprazole delayed realize 40 mg, iron supplement 15 cc, gabapentin 400 mg, probiotic supp 1 cap magnesium oxide 400 mg, glycopyrrolate 1 mg, ropinirole hcl 0.25 mg, allergy relief 180 mg LVN A prepared the medications on the medication cart and opened the capsules and mixed them in one medication cup and then crushed all the tablets together and placed them in one medication cup . LVN A then proceeded to the resident's room with three medication cups of medicine and informed Resident #32 he was going to administer his medications via the g-tube. LVN A checked for placement and residual and then flushed with about 40 cc of water and then proceeded to administer medications. After administering the liquid potassium, he administered the crushed tablets, but the g-tube clogged up, then he poured the medication back to the drinking plastic cup and poured water to the syringe and tried to unclog the tube several times until it was unclogged. LVN A then added the medication that were in the medication cup with the medications in the plastic cup and mixed all the medications together and administered. After medication administration he then flushed with about 40 cc of water. In an interview on 12/17/24 at 01:46 PM with LVN A he stated where he had worked before, he was able to mix all the medications together cocktail because there was an order but Resident #32 did not have an order to cocktail, so he was supposed to administer the medications separately. LVN A stated when medications being cocktailed could lead to some medications having a chemical interaction that could cause a negative effect on the resident. In an interview on 12/18/24 at 03:07 PM with the DON she stated LVN A had informed her that he did not complete the medication administration right. The DON stated the nurse reported he cocktailed the medications. The DON stated the nurse was not supposed to cocktail the medications unless there was an order to do so, but the resident did not have the order. The DON stated the medications were not supposed to be cocktailed because they could interact and cause and negative effect to the resident. Facility policy review dated 10/23/24 titled Gastrostomy (G-tube) Policy reflected, . This service standard shall serve as a guideline and shall not replace sound clinical judgement based on the resident's condition, status, and plan of care.Unless a resident had an identified and documented risk for fluid overload, G-tube medications will be administered one at a time with a flush of at least 15cc before and after the administration of each medication unless the physician's orders specify otherwise.