STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745019	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James L West Center for Dementia Care	1111 Summit Ave Fort Worth, TX 76102

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 2 of 5 residents (Resident #30 and Resident #79) reviewed for abuse. The facility failed to ensure Resident #79 was free from abuse on 10/07/24. Resident #30, who had a diagnosis of dementia and was relocated from a private room to a semi-private room with roommate Resident #79. The early morning of 10/07/24, Resident #30 woke up and was startled when seeing roommate Resident #79 in the room, which resulted in Resident #30 physically assaulting Resident #79 placing the resident at risk for fear. The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 10/07/24 and ended on 10/11/24. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of accidents, injuries, and hospitalization. Findings included: Record review of Resident #30's admission Record dated 06/12/25 reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #30's quarterly MDS assessment dated [DATE] reflected his diagnoses included unspecified dementia, unspecified severity, with agitation, depression, psychotic disorder, and essential hypertension (high blood pressure). Resident #30's BIMS score was 02 indicating severe cognitive impairment. The MDS further revealed Section E - Behaviors indicated Resident #30 had physical and verbal behavioral symptoms. Record review of Resident #30's Care Plan revised 04/10/25 reflected Focus: [Resident #30] has potential to be physically aggressive r/t Dementia, Poor impulse control. He will hit, kick, bite, and punch at the staff at times. Goal: The resident will demonstrate effective coping skills through the review date. Interventions: Notify MD and or [Name] Psych Services for behavior management and medication review. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation, if response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #79's admission Record dated 06/12/25 reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #79's quarterly MDS assessment dated [DATE] reflected his diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and psychotic disorder. Resident #79's BIMS score was 00 indicating severe cognitive impairment. The MDS further revealed Section E - Behaviors indicated Resident #79 had physical and verbal behavioral symptoms. Record review of Resident #79's Care Plan, undated, reflected Focus: [I] have the potential to become aggressive with other residents due to my dementia . Goal: [I] will have no or fewer episodes of aggression toward self or others during through this look back period. Interventions: Redirect and provide a quiet area away from others. Remove resident and make sure Resident is safe from self and others when resident becomes agitated. Record review of the Provider Investigation Report dated 10/16/24 reflected, Nursing staff alert by resident calling out for help. Upon entering the room staff found Resident #2 [Resident #30] in Resident #1 [Resident #79] bed hitting and biting him. Residents were immediately separated. Head to toe assessment completed. First aid administered. Resident #2 [Resident #30] relocated to another room. Immediate notification by physician, responsible party, and VA. Increase supervision by nursing staff. Resident #1 [Resident #79] was able to return to sleep after incident without noted distress. Resident #2 [Resident #30] was relocated back to previous private room and was able to return to sleep without further distress. Resident #2 [Resident #30] has been in a private room since admission to the facility and was recently moved to a semi-private per resident's family request. It is believed Resident #2 [Resident #30] woke up and thought an intruder was in his room and reacted. Staff educated on Abuse and Neglect, Resident to Resident altercation, safe surveys completed. Record review of Resident #30's progress noted dated 10/07/24 at 01:30 AM by LVN C reflected, This nurse and the CNA's heard a loud shout for help at around 12:30am and found resident on the bed with his roommate. Resident was hitting and biting his roommate. We immediately got resident off roommate's bed. HTT assessment was done on resident. No injuries noted on this resident. Resident was taken to his former room to sleep to avoid any further aggression towards his roommate. MD notified. Record review of Resident #79's progress notes dated 10/07/25 at 01:30 AM by LVN C reflected, This nurse and the CNA's heard a loud shout for help at around 12:30am and found residents' roommate on the bed with him. Resident roommate was hitting and biting him. We immediately got [resident roommate's roommate off this residents' bed]. Resident stated that his roommate got off his bed, came onto him while he was sleeping and started punching, pulling on his hairs, beard and biting him. He then started shouting for help. Residents' HTT assessment was done. Skin tears and scratches noted on his hands in 4 places and bite marks on arm and shoulder. Residents' roommate was taken to another room to sleep to avoid any further aggressions. MD notified. Observation and interview on 06/10/25 at 9:38 AM, revealed Resident #79 was in the dining area. Resident #79 stated he was doing well; and the resident was not a good historian. Resident #79 unable to recall the incident. Observation and interview on 06/10/25 at 10:46 AM, revealed Resident #30 was in the dining area watching television. Resident #30 stated he was doing well; and the resident was not a good historian. Resident #30 was unable to recall incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/10/25 at 7:36 PM, CNA B revealed she was the CNA assigned to Resident #30 and Resident #79 when they had an altercation. She stated during the night she heard yelling coming from Resident #30's and Resident #79's room. She stated she entered the room and observed both residents fighting. She stated she called for help and CNA D and LVN C came in to assist. She stated Resident #30 had got up from his bed, went over to Resident #79's bed and was trying to push him off the bed. She stated she could not recall much of the incident but Resident #30 bit Resident #79 on the arm and scratched him. She stated no major injuries were noted. She stated she was not sure why but Resident #30 was in a private room and was changed to a semi-private room with Resident #79. She stated Resident #30 was moved back to his previous private room that night. She stated Resident #30 and Resident #79 were roommates for about day. CNA B stated Resident #30 was known to have agitation behaviors but not physical behaviors towards other residents. Interview on 06/10/25 at 8:18 PM, LVN D stated she was the nurse assigned to Resident #30 and Resident #79 when they had the altercation. She stated Resident #30 had a private room and was moved to a semi-private room with Resident #79. She stated she was called to the room by one of the CNAs, there was yelling coming out of the room. She stated Resident #30 had gotten up to use the restroom but was confused when he saw another person in the room and got startled. She stated Resident #30 was trying to push Resident #79 out of the bed. She stated they intervened and separated both residents. LVN D stated Resident #30 was moved to his previous private room. She stated Resident #79's injuries were superficial, he had small scratches and a small bite to the arm; no blood or broken skin. She stated it was the first altercation Resident #30 had with another resident. She stated it was the first night they were roommates. Interview on 06/11/25 at 6:52 AM, CNA D revealed she worked the night Resident #30 and Resident #79 got into an altercation. She stated she was called to the room to assist. She stated Resident #30 was confused and woke up in the middle of the night and was startled when he observed another person in his room. She stated prior to the altercation during rounds Resident #30 was observed in bed sleeping. She stated Resident #30 was not used to having someone else in the room and was not used to the change. She stated the altercation happened on Resident #79's bed. She stated Resident #30 got up to probably use the restroom and thought Resident #79 was on his bed. She stated Resident #79 had scratches and was bit on the arm. She stated she believed it was the first night as roommates. CNA D stated Resident #30 was not known to have behaviors towards other residents. Interview on 06/12/25 at 1:36 PM, the DON revealed Resident #30 was in a private room since admission; however, the family requested for Resident #30 to be moved to a semiprivate room due to finances. She stated Resident #30 was moved to Resident #79's room. She stated Resident #30 and Resident #79 were roommates for a day or two. She stated Resident #30 got up from his bed and got confused when he saw another resident in his room. She stated Resident #30 thought Resident #79 was a stranger and started to hit resident. She stated Resident #79 began screaming, staff entered the room and intervened. She stated Resident #79 sustained superficial scratches and a bite mark. She stated it did not break the skin, it was superficial, it was only the imprint. She stated Resident #79 did not require hospitalization; they obtained a physician's order for ointment to be applied on the bite mark. She stated within a week Resident #79's injuries healed. She stated the interventions they put in place were Resident #30 was moved back to a private room, frequent monitoring, and staff were all in-serviced on abuse and neglect, and resident to resident altercations. She stated that was the first incident that occurred with Resident #30 being physical with another resident. She stated Resident #30 did not exhibited any behaviors prior to the incident. She stated they were not required to complete any assessments prior to moving a resident to another room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/12/25 at 3:32 PM, the Administrator revealed she was made aware of the incident between Resident #30 and Resident #79; however, she was out for a week when the incident occurred. She stated she was notified by the DON of the incident. She stated her expectations when an altercation occurred was the staff should intervene, separate the residents, make sure residents were safe, assess for any injuries s and find out what triggered the altercation. She stated in the incident between Resident #30 and Resident #79, Resident #30 was moved from a private room to a semiprivate room with Resident #79. She stated Resident #30 was confused seeing another resident in his room. She stated Resident #30 was moved back to a private room. She stated Resident #30 never exhibited any aggressive behaviors towards other residents. She stated Resident #30's family wanted to move Resident #30 to a semiprivate room due to cost reduction. She stated she was not sure if a conversation was done with the family regarding the potential risk of moving the resident. She stated if Resident #30 had exhibited any behaviors they would have not recommended the resident to be placed with a roommate. She stated the interventions they put in place were Resident #30 was moved back to a private room, frequent monitoring, and staff were all in-serviced on abuse and neglect, and resident to resident altercations. She stated the family should be informed of any potential adverse effects may occur and potential of residents not getting along. She stated staff should supervise and monitor how the residents interact/behave due to room change. She stated they went over the monitoring during morning meetings on how the residents adjusted to the change. She stated there could be risks involved when moving a resident to another room, could cause an adverse effect on the resident. Record review of the facility's current, undated Identifying Types of Abuse policy reflected the following: As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents. 1. Abuse of any kind against residents is strictly prohibited. . 5. Abuse toward a resident can occur as: a. resident-to-resident abuse. Prior to the HHSC investigation, the facility took the following actions to correct the noncompliance: Record review of Resident #30's Skin assessment and SBAR completed on 10/07/24, revealed no concerns noted. Record review of Resident #30's census report, revealed Resident #30 was moved to a private room on 10/07/24. Record review of Resident #79's Skin assessment, Change in Condition Evaluation and SBAR completed on 10/07/24. Skin assessment reflected Resident #79 sustained a skin tear on the right forearm, left outer elbow, left forearm, and bruising to the left forearm. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Safe Surveys were completed on 10/11/25 with eleven residents and revealed no issues noted. Record review of facility In-Service Training dated 10/10/24 and 10/11/25, reflected nursing staff from 7:00 AM-7:00 PM and 7:00 PM-7:00 AM were in-serviced on Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish. It may also include depriving the resident of goods and services necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse can be physical, verbal, sexual, financial, emotional and neglect . If abuse is suspected, ensure resident is safe and report the allegations. The abuse coordinator is [Administrator] [phone number] and she needs to be contacted immediately if any abuse is suspected. If there is a resident-to-resident altercation, provide safety of the resident, provide one on one if needed, refer to for evaluation as needed, and ensure that the residents are separated from one another. If the resident is combative, make sure they are safe, remove the other residents, and if needed send the resident out for further interventions with psych services. Interviews on 06/10/25 from 1:21 PM through 06/12/25 to 3:45 PM with CNA B, LVN C, CNA D, CNA H, CNA I, CNA J, LVN K, CNA L, CNA M, RN N, CNA O, CNA P, LVN Q, CNA R, LVN A, ADON S and ADON T revealed the facility staff were able to verify education was provided to them. The nursing staff stated they were educated on different types of abuse/neglect and resident to resident altercations. Staff monitoring behaviors, redirecting, provide activities and round checking. Staff provided the types of abuse were physical, mental, financial, and verbal. Staff stated they would intervene if witness a resident-to-resident altercation, separate, ensure safe, and assess residents. Staff revealed they would report any abuse and neglect concerns to the Abuse Coordinator, the Administrator, immediately if they witness or observed any of these signs.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for two of two residents (Residents #47 and #73) reviewed for catheter care. The facility failed to ensure both Resident #47 and Resident #73 had a physician's order for an indwelling catheter. This failure could place residents who had incontinence at risk for infections and improper treatment. Findings included: Record review of Resident #47's face sheet dated 06/12/25, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #47's Comprehensive MDS assessment dated [DATE] reflected Resident #47 had a BIMS score of 05 indicating Resident #47 had a severe cognitive impairment with diagnoses including Depression (persistent feeling of sadness), Anxiety Disorder (mental health conditions of excessive fear, worry, dread that interferes with daily life), hypertension (high blood pressure) and Alzheimer's Disease (progressive brain disorder slowly damaging memory, thinking, and behavior). The MDS reflected Resident #47 had use of an indwelling catheter. Record review of Resident #47's undated care plan reflected Resident #47 had indwelling Suprapubic Catheter. Goal: Resident will be/remain free from catheter-related trauma. Interventions included Catheter: last changed 05/15/25, change catheter monthly. Catheter: The resident has 16fr indwelling suprapubic catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Monitor for signs and symptoms of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to medical doctor for signs/systems of urinary tract infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Record review of Resident #47's Treatment Administration Record for June 2025 revealed. Document Output every shift start date 04/28/25 -06/12/25. Record urinary output each shift start date 05/16/25-06/12/25. Suprapubic catheter care every shift start date 04/28/25. Change Suprapubic catheter as needed when compromised as needed start date 05/14/25. Record review of Resident #47's physician's orders did not reflect an order for catheter use or what French gage required however the orders revealed: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Change Suprapubic catheter PRN when compromised as needed. Active 5/14/2025 Change suprapubic catheter on the 15th of every month evening shift. every evening shift starting on the 15th and ending on the 15th every month. Active 5/15/2025 Document Output every shift. Active 4/28/2025 Suprapubic catheters care every shift. Active 4/28/2025 ENHANCED BARRIER PRECAUTION EVERY SHIFT: SUPRAPUBIC CATHETER No directions specified for order. Active 4/28/2025 Interview on 06/10/25 at 9:07 AM with Resident #47 revealed he did have a catheter, which he emptied himself and had no issues or concerns with it. Resident #47 stated staff was very helpful with it. Resident #47 was not able to express his need for the catheter. Interview on 06/11/25 at 1:57 PM with LVN A revealed she was aware that Resident #47 required use of a catheter. According to LVN A she was not able to locate an order for use of the catheter, which should have included the proper gauge to use for replacement. LVN A stated she checked him earlier and she did not have any concerns with his catheter. LVN A stated the admitting nurse was responsible for ensuring the catheter order was entered upon admission. LVN A stated the ADON and the DON would be responsible to verify that all orders were entered. LVN A said not having an order for use of the catheter placed Resident #47 at risk of staff using the wrong supplies, however staff should replace the same gage as they took out. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 06/11/25 at 3:03 PM with LVN A, revealed she wanted the surveyor to see an order for Resident #47's catheter use had been added. The physician's order revealed: Change suprapubic catheter on the 15th of every month evening shift. Size16FR/10cc every evening shift starting on the 15th and ending on the 15th every month -Start Date- 06/15/2025. No further interview was completed with LVN A about the order not being complete. 2. Record review of Resident #73's face sheet dated 06/12/25, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #73's Comprehensive MDS assessment dated [DATE] reflected Resident #73 had a BIMS score of 11 indicating Resident #73 had moderate cognitive impairment with diagnoses including Obstructive uropathy (disorder that occurs when urine flow is obstructed), Depression (persistent feeling of sadness), Anxiety Disorder (mental health conditions of excessive fear, worry, dread that interferes with daily life), Psychotic Disorder (mental disorder characterized by a disconnection from reality), stroke (damage to the brain from disruption of blood supply), hypertension (high blood pressure) and Alzheimer's Disease (progressive brain disorder slowly damaging memory, thinking, and behavior). The MDS reflected Resident #73 had use of an indwelling catheter, with use of supervision or touching assistance with toileting. Record review of Resident #73's undated care plan reflected Resident #73 had indwelling catheter related to enlarged prostate, terminal condition. Goal: Resident will be/remain free from catheter-related trauma. Interventions included to assist as needed with maintaining personal cleanliness. Catheter (16FF 10cc). Position catheter bag and tubing below the level of the bladder. Observe for and report to the nurse any complaints of discomfort on urination and increased frequency of urination. Secure catheter tubing to leg to minimize trauma to the insertion site and make sure that the tubing is free of kinks and urine is present in the tube. When providing assistance, observe for and report any of the following to the nurse: pain, burning, blood-tinged urine, foul smelling urine, change mental status, change in behavior, such as confusion, increased restlessness or wandering. Record review of Resident #73's June 2025 Treatment Administration Record reflected: Catheter care - Wash with soap and water around the insertion site daily and as needed start date 08/08/24. May irrigate the indwelling catheter with 60mls of normal saline every shift as needed to maintain patency as needed for Obstructive uropathy. Start date 02/12/25. Record review of Resident #73's physician's orders did not reflect an order for catheter use or what French gauge required; however, the orders reflected: ENHANCED BARRIER PRECAUTION EVERY SHIFT: BPH (CATHETER) every shift Active 1/22/2025 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Catheter care - Wash with soap and water around the insertion site daily and prn every day shift Active 8/8/2024 Monitor the stat lock on the right thigh for skin integrity and that it is holding well. every shift Active 8/1/2024 Ensure the placement of the catheter Q shift and that it is draining. every shift Active 8/1/2024 Document the output of the catheter every shift every shift. Active 8/1/2024 Ensure that catheter is to gravity and draining Q shift every shift for catheter. Active 8/1/2024 May irrigate the indwelling catheter with 60 mls of normal saline every shift PRN to maintain patency as needed for Obstructive uropathy Active 2/12/2025 Observation and interview on 06/10/25 at 9:43 AM revealed Resident #73 sitting in the dining room. The resident had a catheter hanging underneath his wheelchair, and it was covered with a blue bag. Resident #73 stated had a catheter, and he he did not have a problem with his catheter. Resident #73 was not able to express his need for the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/11/25 at 2:05 PM with LVN A revealed she was aware that Resident #73 required the use of a catheter. According to LVN A she was not able to locate an order for the use of the catheter, which should have included the proper gauge to use for replacement. LVN A stated Resident #73 was on hospice care, the nurse had entered earlier to check on resident. According to LVN A, she knew what size catheter gauge to use because the hospice nurse left supplies that included 16FR to be changed on the 15th of June. According to LVN A she was not aware the order for Resident #73 was not present, and the admitting nurse should have entered it upon his admission and the ADON/DON were responsible for ensuring all orders had been entered. LVN A stated there would not be any risk to Resident #73 not having an order for catheter use and correct gauge to use because nursing staff would look at the gauge they were removing and replace with the same gauge. Record review of Resident #73's hospice care book revealed a document Physician Order dated 11/11/24 for Resident #73, physician written order Admit Diagnosis: .May change 16FR 10cc catheter as needed! Interview on 06/12/25 at 12:20 PM with ADON A revealed she expected nurses to enter all orders upon admission of each resident. ADON A stated when she entered and checked orders, she ensured an order would be entered for catheter use and it included the gauge to use. ADON A stated there was no risk to residents because they would replace the same size gauge that they removed. ADON A stated, You can see the gauge at the tip of the catheter before you change it out therefore you will ensure you get the proper supplies before changing. ADON A stated nurses were responsible for entering the orders for catheter use, reviewing the orders, and changing the catheters per the order or as needed. Interview on 06/12/25 at 12:24 PM with the DON revealed there should be an order for catheter use, care and it should include the gauge. The DON stated the admitting nurse should have entered the order upon his admission and the ADON should have reviewed the orders to ensure the orders for his care were entered. The DON stated not having the order for use and gauge size placed Resident #47 at risk of distress, however nurses are responsible for looking at the catheter to verify the size prior to changing it out. Record review of the facility's Catheter Care, Urinary policy, dated 2001, reflected: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Review the resident's care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed. Record review of the facility's Charting and Documentation policy, dated 2001, reflected: All services provided to the resident shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Treatments or services performed is to be documented in the resident medical record. (continued on next page)

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	745019	A. Building B. Wing	06/12/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Entries may only be recorded in the resident's clinical record by licensed personnel (RN, LVN, physician, therapist) in accordance with state law and facility policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 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 two of six residents (Resident #21 and Resident #38) reviewed for medication administration. 1. LVN G failed to administer Timolol Maleate Ophthalmic Solution 0.5 % (Timolol Maleate (Ophth) (a prescription medicine used to treat glaucoma) to Residents #21 and #38 as ordered by the physician. 2. LVN A failed to order Timolol maleate Ophthalmic solution 0.5% (Timolol Maleate (Ophth) (a prescription medicine used to treat glaucoma) for Residnet#21 and #38 after administering the last dose on 06/10/25. These failures could place residents at risk of not receiving the intended therapeutic benefits of prescribed medications. Findings included: 1. Record review of Resident #21's quarterly MDS assessment, dated 04/13/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The assessment reflected the resident's cognition was severely impaired with a BIMS of 7. The resident had diagnosis which included acute angle-closure glaucoma, unspecified eye (is an ocular emergency that results from a rapid increase in intraocular pressure due to outflow obstruction of aqueous humor). Record review of Resident #21's June 2025 Physician's Orders revealed Timolol Maleate Solution 0.5 %. Instill 1 drop in both eyes in the morning for glaucoma. Observation on 06/11/25 at 09:11 AM revealed LVN G prepared medications outside of Resident's#21's room. She failed to administer Timolol Maleate Solution 0.5%. Instill 1 drop in both eyes in the morning for glaucoma making Resident #21 miss the morning dose. 2. Record review of Resident #38's comprehensive MDS assessment, dated 04/21/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. The assessment reflected the resident cognition was severely impaired with a BIMS of 0. The resident had diagnoses which included unspecified glaucoma (is an ocular emergency that results from a rapid increase in intraocular pressure due to outflow obstruction of aqueous humor). Record review of Resident 38's June 2025 Physician's Orders revealed Timolol Maleate Solution 0.5 %.Instill 1 drop in both eyes in the morning for glaucoma. Observation on 06/11/25 at 09:18 AM revealed LVN G prepared medications for Resident #38. She failed to administer Timolol Maleate Solution 0.5 %.Instill 1 drop in both eyes in the morning for glaucoma making Resident #38 miss the morning dose. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/11/25 at 10:00 AM with LVN G regarding not administering Timolol Maleate Solution 0.5 % to Residents #21 and #38 for glaucoma as ordered by the doctor, she said she did not have the eye drops and she had ordered and had notified the doctor. She said it was all nurse's responsibility to order medications when they had a supply of three days left. LVN G stated the nurse that gave the last dose was supposed to reorder. She stated failure to refill the medication on time would cause the resident to miss doses and fail to get the therapy needed. She said she had in-services on medication administration and ordering. She stated she knew not giving the medication could result in having medication error and the glaucoma may get worse. Interview with LVN A on 06/12/25 at 9:26 AM, regarding Resident#21 and Resident #38's Timolol Maleate Solution 0.5% eye drops, revealed she was the nurse who administered the last doses on 06/10/25 to both residents and she forgot to place a refill order to the pharmacy. She stated she got busy and forgot to refill the eye drops. She stated she forgot to notify the management. She stated it was the nurse's responsibility to refill and order medication when they had 1 week supply left. She stated it was nurses' responsibility to check the cart every shift and order what was missing. LVN A stated failure to order the medication on time would lead to the resident missing the medication and the glaucoma may worsen. She stated she had done in-services on medication administration. Interview with the ADON on 06/12/25 at 12:23PM, she stated LVN A was the one that administered the last dose of the eye drops for both residents and she forgot to re-order for refill. She stated there was no specific time when nurse are supposed to order medications and she is new to the facility, and she is not aware of the facility protocol for refills. She stated the nurses are supposed to check carts and she follow up. She was not specific how often she follows up on checking the carts. She stated she was not a doctor to know the risk involved when Residents #21 and #38 missed the eye drops. Interview on 06/12/25 at 1:31 PM with the DON revealed the nurses should follow the facility's policy for medication administration and ordering. She stated nurses should order when they had a 3 days' supply left. She said she was notified of the missed doses for Residents #21 and #38 and the eye drops were ordered. She stated the facility had a monthly pharmacy audit of the cart and the ADON was responsible for auditing the cart weekly. She could not recall when the carts were last audited. She stated the risk of the medication being missed depended on what medication was missed and they should notify the doctor for assessment of residents that had missed medications. The DON stated she had done skills check off with all nurses and she could not recall when. Record review of the facility's training records on 06/12/15 revealed a medication administration in-service dated 01/29/25 and LVN A was in attendance. Record review of the facility's Medication and Treatment Orders policy, dated July 2016, reflected: .11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 6.25% based on 2 errors out of 32 opportunities, which involved two of six residents (Resident #21 and Resident #38) reviewed for medication errors. LVN G Failed to administer Timolol Maleate Ophthalmic Solution 0.5 % (Timolol Maleate (Ophth) (a prescription medicine used to treat glaucoma) to Residents #21 and #38 as ordered by the physician. These failures could place residents at risk of not receiving the intended therapeutic benefits of prescribed medications. Findings included: 1. Record review of Resident #21's quarterly MDS assessment, dated 04/13/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. The assessment reflected the resident's cognition was severely impaired with a BIMS of 7. The resident had diagnosis which included acute angle-closure glaucoma, unspecified eye (is an ocular emergency that results from a rapid increase in intraocular pressure due to outflow obstruction of aqueous humor). Record review of Resident #21's June 2025 Physician's Orders revealed Timolol Maleate Solution 0.5 %. Instill 1 drop in both eyes in the morning for glaucoma. Observation on 06/11/25 at 09:11 AM revealed LVN G prepared medications outside of Resident's#21's room. She failed to administer Timolol Maleate Solution 0.5 %.Instill 1 drop in both eyes in the morning for glaucoma making Resident #21 miss the morning dose. 2. Record review of Resident #38's comprehensive MDS assessment, dated 04/21/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. The assessment reflected the resident cognition was severely impaired with a BIMS of 0. The resident had diagnoses which included unspecified glaucoma (is an ocular emergency that results from a rapid increase in intraocular pressure due to outflow obstruction of aqueous humor). Record review of Resident 38's June 2025 Physician's Orders revealed Timolol Maleate Solution 0.5 %.Instill 1 drop in both eyes in the morning for glaucoma. Observation on 06/11/25 at 09:18 AM revealed LVN G prepared medications for Resident #38. She failed to administer Timolol Maleate Solution 0.5 %.Instill 1 drop in both eyes in the morning for glaucoma making Resident #38 miss the morning dose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/11/25 at 10:00 AM with LVN G regarding not administering Timolol Maleate Solution 0.5 % to Residents #21 and #38 for glaucoma as ordered by the doctor, she said she did not have the eye drops and she had ordered and had notified the doctor. She said it was all nurse's responsibility to order medications when they had a supply of three days left. LVN G stated the nurse that gave the last dose was supposed to reorder. She stated failure to refill the medication on time would cause the resident to miss doses and fail to get the therapy needed. She said she had in-services on medication administration and ordering. She stated she knew not giving the medication could result in having medication error and the glaucoma may get worse. Interview with LVN A on 6/12/25 at 09:26 AM, regarding Resident#21 and Resident #38's Timolol Maleate Solution 0.5 % eye drops , she revealed she was the nurse that administered the last doses on 6/10/25 to both residents and she forgot to place a refill order to the pharmacy. She stated she got busy and forgot to refill the eye drops. She stated she forgot to notify the management. She stated it was the nurse's responsibility to refill and order medication when they had 1 week supply left. She stated it was nurses' responsibility to check the cart every shift and order what was missing. LVN A stated failure to order the medication on time would lead to the resident missing the medication and the glaucoma may worsen. She stated she had done in-services on medication administration. Interview with the ADON on 06/12/25 at 12:23PM, she stated LVN A was the one that administered the last dose of the eye drops for both residents and she forgot to re-order for refill. She stated there was no specific time when nurse are supposed to order medications and she is new to the facility, and she is not aware of the facility protocol for refills. She stated the nurses are supposed to check carts and she follow up. She was not specific how often she follows up on checking the carts. She stated she was not a doctor to know the risk involved when Resident #21 and #38 missed the eye drops. Interview on 06/12/25 at 1:31 PM with DON revealed that nurses should follow the facility's policy for medication administration and ordering. She stated nurses should order when they had a 3 days' supply left. She said she was notified of the missed doses for Residents #21 and #38 and the eye drops were ordered. She stated the facility had a monthly pharmacy audit of the cart and the ADON was responsible for auditing the cart weekly. She could not recall when the carts were last audited. She stated the risk of the medication being missed depended on what medication was missed and they should notify the doctor for assessment of residents that had missed medications. The DON stated she had done skills check off with all nurses and she could not recall when. Record review of the facility training records on 06/12/15 revealed a medication administration in-service dated 01/29/25 and LVN A was in attendance. Record review of facility's policy on Medication and treatment orders dated July 2016, reflected: .11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for two of five residents (Residents #22 and #54) completed and accurate records. 1. The facility failed to ensure Resident #22's ordered Buspirone medication included an indication for use in his physician's orders. 2. The facility failed to ensure Resident #54's ordered Cymbalta medication included an indication for use in her physician's orders. The facility failures could place residents at risk of having inaccurate medical records. Findings included: 1. Record review of Resident #22's admission Record, dated 06/12/25, reflected the resident was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #22's Annual MDS Assessment, dated 04/06/25, reflected he had a BIMS score of 06, indicating moderate cognitive impairment. His active 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), anxiety disorder (a group of mental health conditions characterized by excessive fear, worry, or dread that interferes with daily life), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and post-traumatic stress disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event). His MDS also indicated he received antianxiety medications. Record review of Resident #22's Order Summary Report, dated 06/12/25, reflected the following: busPIRone [sic] HCl Oral Tablet 7.5 MG (Buspirone HC), Give 1 tablet by mouth every morning and at bedtime with a start date of 07/04/24. Record review of Resident #22's MAR for June 2025 reflected he had received his ordered buspirone every day, twice a day for the month of June 2025. Record review of Resident #22's Care Plan, revised on 01/06/25, reflected the following: Focus: The resident has Anxiety [sic] and is on antianxiety r/t Buspirone . Observation on 06/10/25 at 9:32 AM of Resident #22 revealed he was involved in an activity with other residents. Resident #22 did not appear to be able to answer questions regarding his medications due to his cognition level. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/12/25 at 9:51 AM with RN E revealed she usually included an indication for use in a resident's medication order once it was entered onto the chart. RN E said Resident #22 was prescribed buspirone for his anxiety disorder. 2. Record review of Resident #54's admission Record, dated 06/12/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #54's Quarterly MDS Assessment, dated 04/20/25, reflected she had a BIMS score of 00 indicating severe cognitive impairment. Her active diagnoses included Alzheimer's Disease (a progressive brain disorder that slowly destroys memory and thinking skills, eventually impairing the ability to carry out simple tasks), anxiety disorder (a group of mental health conditions characterized by excessive fear, worry, or dread that interferes with daily life), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Her MDS indicated she received antidepressants. Record review of Resident #54's Order Summary Report, dated 06/12/25, reflected the following: Cymbalta Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl), Give 1 capsule by mouth at bedtime with a start date of 03/31/25. Record review of Resident #54's MAR for June 2025 reflected she had received her ordered Cymbalta every day for the month of June 2025. Record review of Resident #54's Care Plan, revised on 04/23/25, reflected the following: Focus: The resident uses antidepressant medication r/t Depression . Interview on 06/12/25 at 10:05 AM with LVN F revealed Resident #54 was receiving Cymbalta for her depression. LVN F said normally when staff entered a medication order into the chart they included the indication for use or diagnosis as well because that was part of the process. LVN F said she was not sure why it was not originally included in the order. Interview on 06/12/25 at 12:30 PM with the DON revealed the nurse who entered a resident's medication into their chart would also add an indication for use. The DON said normally the nurse managers checked to see that was completed during care plan meetings with that resident. The DON said staff were trained to ensure they included the indication for use or diagnosis related to a medication that a resident was taken. The DON said there was no risk for not having an indication for use included with a medication order in a resident's chart. Record review of the facility's Medication and Treatment Orders policy, dated 2001, reflected the following: . 9. Orders for medications must include: e. clinical condition or symptoms for which the medication is prescribed .