STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675172	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GULF HEALTHCARE CENTER - PORT ARTHUR	6600 NINTH AVE PORT ARTHUR, TX 77642

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 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** Based on observation, interview and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 of 21 residents reviewed for assessments. (Resident #16) The most recent MDS assessment for Resident #16 did not indicate the resident had contracted fingers/hand. This failure could place residents at risk for not receiving appropriate care and services to maintain their highest practicable well-being. Findings included: Physician orders [REDACTED].#16, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. The orders with a start date of 11/6/19 indicated the resident was to have a splint applied daily for 8 hours as tolerated. The most recent MDS dated [DATE] did not indicate Resident #16 had a limited ROM to the upper extremities. A care plan dated 12/24/19 indicated Resident #16 had limited mobility. The interventions indicated staff were to monitor the resident for contractures forming or worsening. During the following observations it was noted Resident #16 had contractures to the left wrist and fingers. The left wrist was contracted inward, and the fingers were contracted up towards the palm of the hand: *[DATE] at 9:21 a.m.; *[DATE] at 12:10 p.m.; *[DATE] at 2:41 p.m. *3/10/20 at 10:42 a.m.; *3/10/20 at 1:04 p.m.; and *3/11/20 at 8:00 a.m.; During an interview on 3/11/20 at 10:39 a.m., MDS nurse B said the MDS assessment dated [DATE] for Resident #16 did not indicate the resident had a limited ROM to the upper extremities and was not coded correctly. During exit conference on 3/11/20 at 12:45 p.m., the facility was given the opportunity to provide additional information related to these findings. No additional information was provided.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a baseline care plan was developed that included instructions needed to provide effective care for 3 of 21 residents reviewed for care plans. (Residents #57, 70, and 171) The facility did not develop a complete and accurate baseline care plan for Residents #57, 70, and 171. This failure could place residents at risk for not receiving the appropriate care and services to maintain their highest practicable well-being. Findings included: Physician orders [REDACTED].#57, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. admission orders [REDACTED]. The admission MDS dated [DATE] indicated Resident #57 had pressure injuries and was on a diuretic. A MAR indicated [REDACTED]. The baseline care plan dated 2/11/20 for Resident #57 did not contain the following required information: *Initial admission goals; *Special treatments such as O2 or wound care; *Prescribed diuretics; *A list of medications/instructions for use; *Current skin integrity issues; *social service needs; *baseline summary; *signature of resident and representative; and *signatures of staff completing the baseline care plan. 2. Physician orders [REDACTED].#70, admitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The orders indicated Resident #57 was admitted with a deep tissue injury to sacrum and a PICC (peripherally inserted central catheter used to instill antibiotics intravenously). The admission MDS dated [DATE] indicated Resident #70 had received IV medications and was a risk for pressure ulcers/injuries. A March 2020 MAR for Resident #70 indicated orders for [MEDICATION NAME] sodium 2 gm IV every 4 hours for infection until 3/6/20 with a start date of 2/22/20. The baseline care plan dated 2/21/20 for Resident #70 did not contain the following required information: *Initial admission or discharge goals; *A list of medications/instructions for use; *social service needs; * indication for presence of PICC line/care needed; *indication for presence of skin problems; * baseline summary; *signature of resident and representative; and *signatures of staff completing the baseline care plan. 3. Physician orders [REDACTED].#171, admitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The orders indicated the resident was admitted with a PICC line to his right upper arm and required O2. The admission MDS for Resident #171 was in process and not due at the time of survey. A March 2020 MAR indicated [REDACTED]. The baseline care plan dated 2/28/20 for Resident #171 did not contain the following required information: *Code status; *Initial admission goals; *Oxygen therapy; *A list of medications/instructions for use; *social service needs; *indication for presence of PICC line/care needed; *dietary preferences; *baseline summary; *signature of resident and representative; and *signatures of staff completing the baseline care plan. During an interview on 3/11/20 at 10:30 a.m., the DON acknowledged the baseline care plans for Residents #57, 70, and 171 were not completed and did not have some of the required documentation and should have. A policy dated August 2006 titled Care Plans-Preliminary indicated the following: . A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission. During exit conference on 3/11/20 at 12:45 p.m., the facility was given the opportunity to provide additional information related to these findings. No additional information was provided.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a person-centered comprehensive care plan was developed and implemented to meet the resident's preferences and goals, and address the resident's medical, physical, mental and psychosocial needs for 5 of 21 residents reviewed for comprehensive care plans and 1 of 21 residents reviewed for acute care plans. (Resident #4, 11, 17, 43 and 67) * The facility did not develop an acute care plan, when Resident #4 was diagnosed with [REDACTED].* The facility did not develop and develop a care plan for PASRR status for Resident #s 11 and 67. *The facility did not implement the care plan for code status as ordered by the physician for Resident #s 17 and 43. This failure could place residents at risk for not receiving the appropriate care and services to maintain their highest practicable well-being. Findings included: 1. Physician orders [REDACTED].#4, admitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The orders indicated the resident had an indwelling urinary catheter and was ordered [MED] (double strength) 800-200 mg one tablet by mouth two times a day for 7 days for UTI with a start date of 3/4/20. The most recent MDS dated [DATE] indicated Resident #4 had a [DIAGNOSES REDACTED]. The care plan dated 11/1/19 did not indicate Resident #4 had a [DIAGNOSES REDACTED]. During an observation and interview on 3/10/20 at 10:42 a.m., Resident #4 had an indwelling urinary catheter. The resident said he had been having UTIs ever since the catheter was inserted in the hospital. During an interview on 3/10/20 at 1:29 p.m., MDS nurse B said there was not an acute care plan for Resident #4's UTI or antibiotic ordered 3/4/20. 2. Physician orders [REDACTED].#11, readmitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #11 had a serious mental illness and was considered to be positive for PASRR. The PASRR level 1 screening dated 10/25/19 indicated Resident #11 had a mental illness. The PASRR evaluation dated 10/28/19 indicated Resident #11 had a serious mental illness and would be considered positive for PASRR. The comprehensive

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675172	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GULF HEALTHCARE CENTER - PORT ARTHUR	6600 NINTH AVE PORT ARTHUR, TX 77642

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) care plan dated 11/1/19 did not include Resident #11's status of being positive for PASRR. The care plan did not contain problems, approaches or goals of working with the local mental health authority for this resident and coordination of care. During an interview on 3/11/20 at 10:26 a.m., MDS nurse B said it should had been care planned and the resident's PASARR status was not addressed in the care plan. During an interview on 3/11/20 at 11:11 a.m., the DON said he expected positive PASRR status to be included in the resident's care plans. 3. Physician orders [REDACTED].#17, admitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The resident had an order for [REDACTED].#17 was moderately impaired of cognition, needed limited assistance for bed mobility and transfer and extensive assistance for toileting, hygiene and bathing. The MDS indicated Resident #17 had [DIAGNOSES REDACTED]. A care plan updated 9/16/19 indicated Resident #17 had a code status of full code. During an interview on 3/11/20 at 10:50 a.m., MDS nurse C said Resident #17's care plan was not updated and was care planned as full code and should be care planned as DNR. During an interview on 3/11/20 at 11:15 a.m. the DON and administrator said the care plan for Resident #17 should have been updated from full code to DNR. 4. Physician orders [REDACTED].#43, admitted on [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #43 had [DIAGNOSES REDACTED]. A physician order [REDACTED].#43 had an order for [REDACTED].#43 did not have a care plan for code status and the code status should have been care planned. During an interview on 3/11/20 at 11:06 a.m., the DON said Resident #43's code status should have been care planned. 5. Physician orders [REDACTED].#67, admitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #67 had a serious mental illness and was considered to be positive for PASRR. The PASRR level 1 screening dated 11/05/19 indicated Resident #67 had a serious mental illness. The PASRR evaluation dated 11/6/19 indicated Resident #67 had a serious mental illness and would be considered positive for PASRR. The comprehensive care plan dated did not include Resident #67's status of being positive for PASRR. The care plan did not contain problems, approaches or goals of working with the local mental health authority for this resident and coordination of care. During an interview on 3/10/20 at 2:00 p.m., MDS nurse B said Resident #67's PASRR status was not addressed in the care plan and it should have been. During an interview on 3/11/20 at 11:11 a.m., the DON said he expected positive PASRR status to be included in the resident's care plans. A Comprehensive Care Plan policy dated October 2010 indicated: . An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. During exit conference on 3/11/20 at 12:45 p.m., the facility was given the opportunity to provide additional information. No additional information was provided.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide 1 of 21 residents with limited range of motion the appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (Resident #16) The facility did not apply a hand roll or splint to Resident #16's contracted fingers/hand. This failure could place the residents at risk for not receiving the appropriate care and services to maintain their highest practicable well-being. Findings included: Physician orders [REDACTED].#16, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. The orders with a start date of 11/6/19 indicated the resident was to have a splint applied daily to elbow and hand for 8 hours as tolerated. The admission MDS dated [DATE] indicated Resident #16 had a limited ROM on one side to the upper extremities. The most recent MDS dated [DATE] did not indicate Resident #16 had a limited ROM to the upper extremities. A care plan indicated Resident #16 had limited mobility. The interventions indicated staff were to monitor the resident for contractures forming or worsening. The clinical record from admission on 11/6/19 to present did not indicate Resident #16 refused to have the splint applied or attempts had been made to put handrolls in the resident's contracted hand. During observations Resident #16's left wrist was contracted inward, and the fingers were contracted up towards the palm of the left hand. The resident did not have a splint or hand roll in the contracted hand as follows on: *[DATE] at 9:21 a.m.; *[DATE] at 12:10 p.m.; *[DATE] at 2:41 p.m. *3/10/20 at 10:42 a.m.; *3/10/20 at 1:04 p.m.; and *3/11/20 at 8:00 a.m. During an observation and interview on 3/11/20 at 8:00 a.m., Resident #16 was eating breakfast. There was no splint or hand roll in the resident's contracted left hand. The DON said the resident did not have a splint or hand roll in the contracted hand and should have one to prevent further contractures. During an interview on 3/11/20 at 8:05 a.m., the director of therapy said Resident #16 was last seen by therapy in December 2019 and had a splint applied, but the splint did not fit well, so they discontinued using it. She said the resident did need a hand roll in her hand to prevent further contractures. During an interview on 3/11/20 at 9:02 a.m., OT D said Resident #16's left arm had so much tone it was contracted up to the body. She said therapy had tried a palm protector, but the hook and the loop were digging into the resident's skin, so they could not use it. She said they ordered a hand roll, however, when it was delivered it was a cone covered in terry cloth and did not have padding, so they did not use it. She said no other hand roll was applied. During an interview on 3/11/20 at 10:24 a.m., RA E said she picked up Resident #16 for services on 12/16/19, after therapy was completed. She said she did not use a hand roll on Resident #16 during restorative care. During the exit conference on 3/11/20 at 12:45 p.m., the facility was asked to provide additional information according to these findings. No additional information was provided.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 1 of 21 residents reviewed for drug regimen. (Resident #27) The facility did not monitor Resident #27 for the side effects of apaxiban (blood thinner that slows down the body's process of making clots). This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest practicable well-being. Findings included: Physician orders [REDACTED].#27, admitted [DATE], was [AGE] years old and had a [DIAGNOSES REDACTED]. The resident was ordered apixaban 5 mg 1 tablet by mouth two times a day for anticoagulant therapy with a start date of [DATE]. The most recent MDS dated [DATE] indicated Resident #27 received anticoagulants 7 times in the last week. A care plan dated 1/6/20 indicated Resident #27 received anticoagulant therapy apixiban and aspirin related to [MEDICAL CONDITION]. The goal was for the resident to not have signs or symptoms of bleeding noted while on anticoagulant therapy. A MAR indicated [REDACTED]. The clinical record from admission on 12/30/19 to 3/11/20 did not indicate Resident #27 was monitored for the side effects, such as unusual bleeding, of apaxiban. During an interview on 3/11/20 at 7:53 a.m., the DON said the resident was not monitored for the side effects of apaxiban and should have been. During the exit conference on 3/11/20 at 12:45 p.m., the facility was given the opportunity to provide additional information related to these findings No additional information was provided.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate monitoring of [MEDICAL CONDITION] drugs was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675172	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GULF HEALTHCARE CENTER - PORT ARTHUR	6600 NINTH AVE PORT ARTHUR, TX 77642

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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) provided for 2 of 21 residents reviewed for [MEDICAL CONDITION] medications. (Resident #'s 17 and 66) *The facility did not monitor Resident #17 for effectiveness, side effects and behavioral symptoms for trazadone (an antidepressant medication), [MEDICATION NAME] (an antidepressant medication), and [MEDICATION NAME] (an antianxiety medication); *The facility did not monitor Resident #66 for effectiveness, side effects and behavioral symptoms for [MEDICATION NAME] (an antidepressant medication), trazadone and the side effects for [MEDICATION NAME] (an antipsychotic medication). This failure could place the residents at risk for adverse consequences of the [MEDICAL CONDITION] medications. Findings included: 1. Physician orders [REDACTED].#17, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. The resident had an order for [REDACTED]. Resident #17's orders included trazadone 100 mg tablet at bed time for depression with an active date of 2/7/20. The most recent MDS dated [DATE] indicated Resident #17 was moderately impaired of cognition, needed limited assist for bed mobility and transfer and extensive assist for toileting, hygiene and bathing. The MDS indicated Resident #17 had [DIAGNOSES REDACTED]. A MAR indicated [REDACTED]. The MAR indicated [REDACTED]. A care plan updated 9/16/19 for Resident #17 indicated the resident had a history of [REDACTED]. The clinical record dated 2/29/20 to 3/10/20 indicated Resident #17 was not monitored for the specific side effects or behaviors for [MEDICATION NAME] or trazadone. During an interview on 3/11/20 at 11:15 a.m. the administrator and DON said that all [MEDICAL CONDITION] medications should be monitored for behaviors and side effects. 2. Physician orders [REDACTED].#66, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. The orders included trazadone 150 mg by mouth at bed time with a start date of 11/6/19 and [MEDICATION NAME] 300 mg by mouth daily with a start date of 11/7/19. The most recent MDS dated [DATE] indicated Resident #66 was moderately impaired of cognition and needed limited assistance for bed mobility and extensive assist for transfer, toileting, hygiene and bathing. The MDS indicated Resident #66 had [DIAGNOSES REDACTED]. A MAR indicated [REDACTED]. The MAR indicated [REDACTED]. A care plan updated 12/9/19 indicated Resident #66 uses [MEDICAL CONDITION] medications related to depression and [MEDICAL CONDITION] and received trazadone, [MEDICATION NAME] and [MEDICATION NAME]. Interventions indicated, . Observe for and report to the nurse any occurrence of behavior symptoms . Observe for and report to the nurse any of the following adverse reactions of [MEDICAL CONDITION] medications: [REDACTED]. The record also indicated Resident # 66 was not monitored for the specific side effects or behaviors for [MEDICATION NAME], trazadone and [MEDICATION NAME]. During an interview on 3/11/20 at 11:15 a.m. the administrator and DON agreed that all [MEDICAL CONDITION] medications should be monitored for behaviors and side effects. A policy dated January 2018 titled Medication Monitoring and Management indicated the following: . In order to maintain the resident's highest level of practicable function and to prevent and minimize adverse consequences related to medication therapy, the facility establishes monitoring standards for certain medications to promote safe and effective use of the medication. During the exit on 3/11/20 at 12:45 p.m. the facility was asked for any additional information related to these findings. No additional information was provided.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 interviews and record reviews, the facility failed to ensure clinical records were accurately documented for 4 of the 21 residents reviewed for clinical records. (Resident #s10, 11, 25 and 53) The MARs were incomplete for residents #10, #11, #25 and #53 on the evening shift on 3/6/2020 and 3/7/2020. This failure could place the residents of not receiving the care and services required. Findings included: 1. Physician orders [REDACTED].#10, admitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED].#11 had impaired cognition and required assistance with ADLs. The care plan dated 1/14/20 indicated Resident #11 had impaired cognition and high blood pressure and required assistance with ADLs. The MAR for Resident #10 dated March 2020 indicated no initials and was blank on the medications as follows: *3/6/2020 at 1700, [MEDICATION NAME] 25 mg; *3/6/20 at 1700, [MEDICATION NAME] 200 mg; and *3/6/20 at 2000, [MEDICATION NAME] 0.4 mg. 2. Physician orders [REDACTED].#11, readmitted on [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The orders included [MEDICATION NAME] (used to treat [MEDICAL CONDITION]) 125 mg 1 tablet at bedtime, [MEDICATION NAME] (reflux disease) 20 mg 1 tablet at bedtime, [MEDICATION NAME] (depression) 50 mg 1 tablet at bedtime, [MEDICATION NAME] ([MEDICAL CONDITION]) 25 mg 1 tablet at bedtime and [MEDICATION NAME] (pain) 10-325 mg 1 tablet 4 times daily. The most recent MDS dated [DATE] indicated Resident #11 was cognitively intact, required extensive assist 1 staff for ADLs and received antipsychotic, antidepressant and opioids during last 7 days. The care plan dated 11/6/19 indicated Resident #11 had history of [MEDICAL CONDITION] and received medication and had chronic pain. The MAR for Resident #11 dated March 2020 indicated no initials on the medications as follows: *on 3/6/2020 at 1500 (3:00 p.m.) for [MEDICATION NAME]; *on 3/6/2020 at 2000 (8:00 p.m.) for [MEDICATION NAME]; *on 3/6/2020 at 2000 (8:00 p.m.) for [MEDICATION NAME]; *on 3/6/2020 at 2000 (8:00 p.m.) for [MEDICATION NAME]; *on 3/6/2020 at 2000 (8:00 p.m.) for [MEDICATION NAME]; *on 3/6/2020 at 2100 (9:00 p.m.) for [MEDICATION NAME] *on 3/7/2020 at 2000 (8:00 p.m.) for [MEDICATION NAME]; *on 3/7/2020 at 2000 (8:00 p.m.) for [MEDICATION NAME]; *on 3/7/2020 at 2000 (8:00 p.m.) for [MEDICATION NAME]; *on 3/7/2020 at 2000 (8:00 p.m.) for [MEDICATION NAME] and *on 3/7/2020 at 2100 (9:00 p.m.) for [MEDICATION NAME]; 3. Physician orders [REDACTED].#25, admitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The orders included medications of [MED] [MED] [MED] 25 units daily and [MEDICATION NAME] 43 units at bedtime, (to control blood sugars), [MEDICATION NAME] 100 mg at bedtime (depression), [MEDICATION NAME] (to prevent [MEDICAL CONDITION]), [MEDICATION NAME] (treat high blood pressure) and [MEDICATION NAME] (for nerve pain). The most recent admission MDS dated [DATE] indicated Resident #25 had impaired cognition and required assistance with ADLs. The care plan dated 11/1/19 indicated Resident #25 had diabetes, [MEDICAL CONDITION] depression and [MEDICAL CONDITION]. The MAR indicated [REDACTED]*3/6/20 at 1700 (5:00 p.m.), [MED] [MED] 25 units daily *3/6/20 at 2100 (9:00 p.m.), [MEDICATION NAME] 43 units at bedtime; *3/6/20 at 2100 (9:00 p.m.), [MEDICATION NAME] 100 mg at bedtime; *3/6/20 at 2100 (9:00 p.m.), [MEDICATION NAME] 100 mg at bedtime; *3/6/20 at 1700 (5:00 p.m.), [MEDICATION NAME] 75 mg 1 tablet 2 times daily; *3/6/20 at 1700 (5:00 p.m.), [MEDICATION NAME] 50 mg tablet three times daily *3/7/20 at 2100 (9:00 p.m.), [MEDICATION NAME] 100 mg at bedtime *3/7/20 at 2100 (9:00 p.m.), [MEDICATION NAME] 43 units at bedtime 4. Physician orders [REDACTED].#53, admitted [DATE], was [AGE] years old and had [DIAGNOSES REDACTED]. The orders included [MED] 30 units at bedtime with accucheck, [MEDICATION NAME] 20 mg at bedtime The most recent admission MDS dated [DATE] indicated Resident #53 was cognitively intact and was visually impaired. The care plan dated 10/31/19 indicated Resident #53 was visually impaired and required assistance with ADLs. The MAR indicated [REDACTED]*3/6/20 at [MEDICATION NAME] at bedtime; *3/7/20 at 2100, [MED] [MEDICATION NAME] 30 units at bedtime with accucheck and *3/7/20 at [MEDICATION NAME] at bedtime. During a phone interview on 3/10/2020 at 11:25 a.m., LVN A said on 3/6/20 and 3/7/20 she had worked hall 200. She said she gave the medications for Residents #10, #11, #25 and #53 but did not document when she gave the medications. During an interview on 3/10/2020, at 11:30 a.m., the DON said the medications should have been documented after giving them and the MAR indicated [REDACTED].j. after administration, . document administration in the MAR, . During the exit on 3/11/20 at 12:45 p.m., the facility was asked for any additional information related to these findings. No additional information was provided. .