STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676481	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Senior Living	118 Trinity Shores Drive Port Lavaca, TX 77979

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview and record review, the facility failed to implement its written policies and procedures that prohibit and prevent abuse, neglect, and misappropriation for 2 of 24 residents (Resident #31 and #64) reviewed for misappropriation. The facility did not conduct training after an allegation of misappropriation of $20 involving Resident #31 on 11/22/24. The facility did not conduct training after an allegation of misappropriation involving the missing of two NARCO pills for Resident # 64 on 11/27/24. This failure could place residents at risk for misappropriation, a diminished quality of life, and psychosocial harm. The findings were: Record review of facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated Revised 2021 read: .Provide staff orientation and training/orientation programs that includes topics such as abuse prevention, identification and reporting of abuse . [ANE policy given to surveyor did not fully address the 7 elements to include investigation response] 11/22/24 Misappropriation Record review of Resident #31's face sheet, dated 12/16/24, reflected a male age 70. The resident was admitted on [DATE] with diagnoses that included: acute kidney failure, hypertension, and Parkinson's disease (brain disease). The RP was listed as: family member. Record review of Resident #31's admission MDS, dated [DATE], reflected a BIMS score was 13 (cognitively intact). (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 12/16/24 at 12:25 PM, revealed Resident #31 was in bed watching TV. The resident was alert and oriented to person and place. The resident stated, .my [family member] gave me the $20 dollars when I went to the hospital. I put the $20 in my lunch box. I cannot prove that the money was stolen. My [family member] told the Administrator about the missing money. [11/22/24] I do not have safe, nor do I want one. I do not keep money in my room. There was no other theft of other property. The resident stated the past Administrator was aware of the missing $20 but the resident was not certain as to whether other staff were aware of the missing $20. During interview on 12/16/24 at 1:00 PM, the past interim Administrator stated he visited with the family and the money was lost or misplaced. The past Administrator stated, the facility's investigation did not reveal that anyone entered his (Resident #31) room. The past Administrator stated that the current plan was to replace the money. The past Administrator stated the resident was offered a locked box or to put money in a trust, but the resident refused. The Administrator stated there were no cameras in the room. The past Administrator stated, Abuse and neglect training was not done .yes we had an allegation of theft . The Administrator stated that in general we do abuse and neglect training when there was an allegation .we should have done the training as part of the 7 elements of ANE. The Administrator added that training was part of the overall ANE facility's policy. The Administrator stated that the family and resident made the allegation of the missing $20 on 11/22/24. The past interim Administrator stated that there was no grievance process to include required training. During interview on 12/16/24 at 2:20 PM, the DON stated she started employment on 12/09/24 and was not aware of the incident involving the alleged theft of $20 involving Resident #31. The DON stated when the incident was reported of alleged misappropriation in November 2024 training on ANE should have started for all staff as part of the facility's ANE policy. The DON stated the training needed to be done for staff to know how to report ANE and recognize ANE. The DON stated that she did not know why the training was not done on 11/11/24. [Except for the past Administrator, the staff was not aware of the missing $20 on 11/22/24.] During an interview on 12/16/24 at 3:10 PM, LVN A stated when there was an allegation of ANE an in-service needed to be conducted for staff to know the signs of ANE and whom to report. LVN A stated she worked with Resident #31 for about 9 months. LVN A stated she did not remember whether she attended an in-service on ANE in November 2024 for the incident on 11/22/24. During an interview on 12/16/24 at 3:10 PM, Med Aide K stated: when there was an allegation of ANE an in-service needed to be conducted so staff knew the signs of ANE and whom to report. Med Aide K stated she worked with Resident #31 for about 3 years. During an interview on 12/17/24 at 8:30 AM, the past Administrator stated that the training done on 12/5/24 incorporated the incident on 11/22/24 but the training was not specific to the incident on 11/22/24. During a telephone interview on 12/17/24 at 10:00 AM, RN B stated the training on ANE on 12/5/24 was general training on ANE and not specific to the incident on 11/22/24. RN B stated, the training did discuss the incident of 11/22/24 as an example of misappropriation and a second example presented at the in-service involved as an example of neglect. Record review of facility's staff list dated 12/16/24 reflected the number of paid staff was 90. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's general ANE training reflected training was done on 12/5/24 which was 13 days after the incident on 11/22/24. Record review of facility's grievance log form 11/22/2024 reflected a family member alleged that $20 was missing out of the Resident #31's shaving kit. Resolution: money was returned on 12/16/24 [after surveyor's entrance]. 11/27/24 Misappropriation Record review of Resident #64 's face sheet, dated 12/18/24 reflected a male age 74. The resident was admitted on [DATE] with diagnoses that included: joint replacement, cancer, and pain. The RP was listed as: resident. Record review of Resident #64 's admission MDS, dated [DATE], reflected the resident's BIMS score was 15 (cognitively intact). Record review of Resident #64's Physician' Orders, dated November 2024, reflected, hydrocodone NARCO) 10-325 every 6 hours for pain and arthritis PRN. Record review of Resident# 64's MAR, dated November 2024, reflected: 11/26/24-No PRN NARCO given. 11/27/24-No PRN NARCO given. 11/28/24-10:52 AM-No entry that the medication (NARCO) was given on 11/28/24 at 3: AM as claimed by LVN H). Count was short 2 NARCO pills. Record review of Resident #64's Nurse's Notes dated from 11/27/24 and 11/28/24 reflected no notes establishing that NARCO was given to Resident #64. During an interview on 12/18/24 at 2:22 PM, the past Administrator stated: he was informed during the change shift on 12/6/24 that the narcotic count was short in an unknown cart. The past Administrator stated, The cart with the missing narcotics (NARCO) [for Resident # 64] was put out service and double locked pending an investigation. The past Administrator stated the DON did a reconciliation and two NARCO pills belonging to Resident #64 were found missing. The past Administrator stated that LVN H was suspended pending an investigation. The past Administrator stated that the facility's investigation could not account for the missing NARCO belonging to Resident #64. The past Administrator stated that LVN H signed the reconciliation form on 11/26/24 and could not account for the missing NARCO. The past Administrator stated that no in-service training was done for the staff except for LVN H on ANE. Record review of facility's investigation file reflected: NARCO count dated 11/27/24- was short 2 pills. Resident #64 was prescribed Hydrocodone 10-325 Mg (delivery of 40 pills on was 7/18/24). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Written Statement by LVN H dated 12/2/24 reflected LVN H had no idea how there were 2 missing NARCO although he/she had signed for the blister pack. LVN H stated he/she left the cart opened and unsecured to help another resident for a short period of time. Statement 11/27/24: LVN A (night shift) identified that the reconciliation was incorrect and notified the DON. Statement 11/27/24: LVN I (day shift) count was incorrect for Resident #64. No in-service training sheets on ANE were present. During an interview on 12/18/24 at 3:21 PM, the DON stated she investigated the diversion and discovered the card in question was delivered in July 2024. The DON stated, the resident discharged home in September 2024 with the NARCO order. The DON stated the resident was readmitted [DATE] with 38 NARCO tablets and there were 2 missing from the card. [The DON stated that the count started with 38 and therefore no NARCO went missing] The card was signed in with 38 NARCOs by 2 nurses. On 11/26/24 the count was off 2 NARCO but LVN H signed for the 2 missing NARCOs. The DON stated LVN H signed for the additional 2 NARCOs. The DON stated, LVN H stated he left the cart opened on 11/27/24 during the night shift. The DON stated, LVN H accepted responsibility for the 2 missing NARCOs caused by the unsecured cart. The DON stated that she realized on 12/16/24 [date of surveyor's entrance] that training was not initiated on the day of the incident on 11/27/24 per the ANE policy; but training was started at the time of surveyor's entrance. [DON tried to explain that LVN H signed a card missing 2 NARCO and the incoming LVN A refused to accept the shift change reconciliation because 2 NARCO pills were missing. LVN H stated that the unsecured medication cart resulted in the 2 missing NARCO] During telephone interview on 12/18/24 at 3:44 PM, LVN A stated she identified that the reconciliation was incorrect on 11/27/24 at 6:00 AM and notified the DON. LVN A stated that LVN H did not give her a reason for the missing NARCO. LVN A stated that LVN H told her that he/she gave the medication (NARCO) to the Resident #64 on 11/27/23 at 3:00 AM and forgot to update the MAR. During a telephone interview on 12/18/24 at 4:17 PM, LVN H stated I was getting the pills for [Resident #64} around 3:00 AM in the morning of 11/27/24 and a call light went off .I left my cart unsecured .that is on me . there was a resident awake (Resident #50) near the cart and might have access to the unsecured cart .I gave the {Resident #64] his medication and at the end of shift if was when 11/27/24 at 6:00 AM) the missing NARCO was discovered . LVN H stated he forgot to document the narcotic sheet for Resident #64 of the NARCO given and also forgot to annotate the MAR November 2024. {The missing NARCO was a PRN medication for Resident #64 and not given on 11/27/24] During telephone interview on 12/18/24 at 5:30 PM, RN J stated she received a call on 11/27/24 about the drug diversion from another staff member. She directed that the Administrator be notified. RN J stated the cart with the missing medication was secured. RN J stated LVN H was suspended pending an investigation. RN J stated that LVN H did not give her an explanation on how the NARCO went missing.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34957 Based on observation, interview and record review, the facility failed to ensure that drugs and biologicals used in the facility were secured and distributed properly for one of four nurse medication carts (Hall 200 nurse medication cart and Hall 300 medication cart) reviewed for drug storage and use, as evidenced by: 1. The nurse medication cart for the 300-hall contained 5 loose pills. These failures could place residents who received medications, including narcotics at risk for not receiving the intended therapeutic effects of their prescribed medications and experiencing unintended and harmful effects of medications prescribed to others and place the facility at risk for drug diversion. The findings included: 1. During an observation and interview on 12/17/24 at 9:15 AM of the nurse cart for the 300 hall with LVN F, revealed 5 loose pills in the bottom of the cart drawers that held the blister packs. When asked what could happen if loose pills are left in the cart, LVN F stated anything could happen if the pills were consumed by a resident for whom they were not prescribed. LVN F stated a resident could be allergic to one of the pills and the consequences could be horrific. During an interview on 12/18/24 at 10:16 AM with the acting DON, when asked what could happen if loose pills are found in the carts, the acting DON stated residents might not receive the medication they needed resulting in a delay in therapy, and if a resident consumed something that was not prescribed for them, the resident could experience adverse effects or an allergic reaction. The acting DON stated her expectation was for the staff to check carts per shift for loose pills. Review of the facility's policy titled Medication Carts and Supplies for Administering Meds dated 10/01/19, reflected the purpose of the mobile medication system is to ensure appropriate control and surveillance of resident assigned medications. Review of the facility's policy titled Disposal of Medications and Medication-Related Supplies dated April 2019, reflected unused, unwanted, and non-returnable medications should be removed from their storage area and secured until destroyed. 50760