STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for 1 of 6 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure that Resident #1's Ingrezza medication was ordered from the pharmacy and received timely, as a result Resident #1's Tardive Dyskinesia worsened. This failure could place residents whose medications were supervised by the facility at risk of experiencing serious side effects from possible interruptions to their medication regimen. Findings included: Record review of Resident #1's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with end-stage kidney disease (a medical condition in which a person's kidneys cease functioning), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), anemia (a condition in which the blood does not have enough healthy red blood cells), major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and osteoporosis (a condition in which bones become weak and brittle). Record review of Resident #1's MDS (Minimum Data Set), dated [DATE] revealed she had a BIMS (Brief Interview for Mental Status) of 15 (cognitively intact); she did not exhibit any symptoms of psychosis or behaviors; she required supervision and set-up assistance from staff for bed mobility, transfers, walking, dressing, eating, toilet use, and personal hygiene; she was independent with bathing; and she was always continent of bowel and bladder. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's care plan updated [DATE] revealed she was on sedative/hypnotic therapy; she used anti-anxiety medications; she used antidepressant medication; and she used antipsychotic medications (Goal: resident will be/remain free of psychotropic drug related complications, including movement disorder .), (Interventions: Administer Ingrezza for Tardive Dyskinesia [a condition affecting the nervous system, often caused by long-term use of some psychiatric drugs. Symptoms include repetitive, involuntary movements, such as grimacing, rapid blinking, tongue thrusting, lip smacking/puckering] .) Observation and interview with Resident #1 on [DATE] at 12:40 p.m. revealed she was alert, oriented, and ambulated via wheelchair. Resident #1 stated she had not received her medication, Ingrezza, since the previous Monday, [DATE]. She stated she asked the nurses about the medication daily, but they always said it was coming tomorrow. She said the Ingrezza was for her Tardive Dyskinesia and since she had not received the medication, she noticed her tongue hung out of her mouth more, her legs went up and down involuntarily more and she did not sleep. She said these symptoms were very frustrating and she was upset because it would take some time for her body to adjust to the medication again. She said she had been up since 3:00 a.m. that day ([DATE]). She said nobody tried to order the medication until Sunday ([DATE]) and Monday ([DATE]) when they told her the pharmacy did not answer the phone. She said the medication came from a specialty pharmacy and nobody knew how to order it. Further observation of Resident #1 at that time revealed her tongue projected from her mouth at times while she talked and while at rest. Record review of Resident #1's, Medication Review Report (Physician's Orders) for [DATE] revealed: Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Notify SW when supply runs low at 8 doses left. Order Status: Discontinued (no date was listed), Order Date: [DATE], Start Date: [DATE]. Record review of Resident #1's, Medication Review Report (Physician's Orders) for [DATE] revealed: Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Call pharmacy for refills (pharmacy name and phone number). Order Status: Active, Order Date: [DATE], Start Date: [DATE]. Record review of Resident #1's MAR for [DATE] revealed: Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Notify SW when supply runs low at 8 doses left. Start Date: [DATE], D/C Date: [DATE]. Further review of the record revealed Ingrezza was administered daily in [DATE] until [DATE]. Doses were not administered [DATE] - [DATE]. Record review of Resident #1's MAR for [DATE] revealed: Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Notify SW when supply runs low at 8 doses left. Start Date: [DATE], D/C Date: [DATE]. Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Call pharmacy for refills (pharmacy name and phone number). Start Date: [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	Further review of the record revealed the medication was not administered on [DATE]. Record review of Resident #1's Nursing Progress Notes for [DATE] revealed: On [DATE] at 8:38 p.m., LVN A wrote, Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia Notify SW when supply runs low at 8 doses left. Medication not available. On [DATE] at 6:27 p.m., LVN B wrote, MAR indicates Social Worker needs to be informed Eight (8) doses before the medication runs out to order it. Today is Saturday Weekend [DATE] (resident informed me she has missed 4 Evening doses - no orders noted to date). I will inform Social Worker at earliest convenience so medication could be ordered ASAP (Note: I was informed by Night Shift Nurse [night shift nurse was not named] that 1. Information for Specialty Pharmacy is on the order, but it is not, it shows old pharmacy information and 2. Social Worker needs to order it). On [DATE] at 6:46 a.m., LVN C wrote, Reported to DON about Ingrezza order needed via Social Worker thru a Specialty Pharmacy. DON will follow up. Day Shift Nurse informed/will monitor situation. On [DATE] at 10:24 a.m., the DON wrote, Spoke with specialty pharmacy and the order for the Ingrezza Capsule 40 MG was called in and the medication will be sent out today and will be delivered tomorrow. In an interview with the DON on [DATE] at 10:30 a.m., she said the facility had trouble getting Resident #1's Ingrezza, which had to be ordered through a specialty pharmacy. She said communication between the facility and the pharmacy was not effective. The DON said once she found out over the weekend ([DATE]) that the medication was not available in the facility, she contacted the specialty pharmacy who said they were trying to get the refill order from a doctor who no longer saw residents at the facility. The DON said she had to wait until Tuesday, [DATE], to call the specialty pharmacy because Monday, [DATE] was a holiday and the pharmacy was closed. She said she contacted the current doctor to refill the medication. She said medication refills should be requested within seven days before they ran out, but none of the nurses ever reported any problems with getting the medication within the seven days. She said regular medications were refilled through their computer system, but since the Ingrezza had to be ordered from a specialty pharmacy, the nurses may not have known how to order it. She said most of the nurses on the 2:00 p.m. - 10:00 p.m. shift (Resident #1 received the Ingrezza during this shift) were agency staff. In an interview with the Social Worker on [DATE] at 11:00 a.m., she stated she was not sure why there was a note to contact her about Resident #1's medication refill. She said she was the one who figured out which pharmacy to order the medication from back in [DATE] (when Resident #1 started taking the medication), so maybe the nurses thought she was the one who had to order the medication. She said in [DATE], she called their regular pharmacy because they did not provide the Ingrezza and they told her the name of the specialty pharmacy who could provide the medication. She said nobody ever notified her when Resident #1 had eight doses of the Ingrezza left, or when it ran out. She said she was not made aware when the nurses had issues with the medication refill. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Administrator on [DATE] at 1:00 p.m., he said he was aware of Resident #1's medication situation. He said one of agency nurses must have put the note in Resident #1's MAR to contact the Social Worker about ordering the medication, but that was not correct. He said the facility's policy was to re-order medications within three days of last dose, but if the medication was hard to get, the nurses should have written a special note on the MAR to try and re-order more than three days ahead. He said he was not aware of any side effects Resident #1 had experienced due to not having her medication. He said even when Resident #1 received the medication daily, she still had some signs of it the Tardive Dyskinesia. He stated he observed and talked to Resident #1 while passing through the hallways and he did not notice anything unusual. In an interview with the DON on [DATE] at 1:15 p.m., she said Resident #1's doctor never stopped seeing residents at the facility, but his NP stopped seeing residents in [DATE]. She said when she found out about the issue on Saturday ([DATE]), she told LVN C to look for any notes from the Social Worker to find the specialty pharmacy's phone number, but LVN C said she could not find it. The DON said she found the name and phone number for the specialty pharmacy, but there was no answer after hours on a Saturday ([DATE]). She said she tried again on Sunday ([DATE]) and Monday ([DATE]) but there was no answer. She said when she called the specialty pharmacy on Tuesday ([DATE]), the representative said Resident #1's prescription was expired and a new order had to be submitted. She said the representative said the pharmacy had been trying to reach the old NP, but they could not reach her. The DON said she called Resident #1's doctor and he wrote a new order. She said she tried to get an order from Resident #1's primary doctor, but they could not write the order because the medication was referred by the psychiatrist. The DON stated the Ingrezza was delivered by the specialty pharmacy 20 minutes ago (on [DATE] 20 minutes prior to the interview) and would be administered to Resident #1 that evening. The DON said she deleted the note on Resident #1's MAR to contact the Social Worker (that was why the initial order for Ingrezza was discontinued on [DATE] and a new order was created on the same day) and instead, wrote the name and phone number of the specialty pharmacy on the MAR. She said she did not know why the nurses did not contact the Social Worker eight days ahead, as the note instructed. She said the nurses did call her, but not eight days before the medication ran out. She said if Resident #1 was out of her medication since last Monday ([DATE]), she (Resident #1) would have found her (the DON) and hounded (harassed) her until the medication was in because that is what she normally did whenever she felt her medications were low. She said most of the 2:00 p.m. - 10:00 p.m. shift were agency nurses, but the facility tried to staff the same nurses who were familiar with their processes. She said they provided an orientation for all agency nurses and gave them her phone number to call with any questions. The DON said her expectation was for the agency nurses to call the Social Worker because that was what the order said. She said the next thing for them to do would have been to follow the chain of command and call her (the DON) or the ADON and bring the issue to their attention sooner. The DON said Resident #1 told her she needed the medication because her tongue and legs were moving more, but she (the DON) did not observe anything unusual about Resident #1. She said although she could not see anything different, maybe Resident #1 could see and feel the difference. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview with LVN B on [DATE] at 1:35 p.m., she said she worked on Saturday ([DATE]) and Resident #1 said she had not received the Ingrezza for the last four nights. She said she looked at Resident #1's MAR and noted the last time the medication was ordered was sometime in [DATE]. She said she saw the note to inform the Social Worker eight doses ahead on Saturday ([DATE]), but she did not see the note before then. She said she called the regular pharmacy because they were the last to fill the order, but they said it had to be filled by a specialty pharmacy because they no longer supplied it. She said he called the DON, who said she would follow up. LVN B said she was familiar with Resident #1 because she had previously cared for her. She said she observed that Resident #1's tongue was doing something a little unusual. She said Resident #1 asked her if she saw anything unusual about her tongue, but she did not want to alarm her, so she said she did not see anything different. She said she told LVN C about the issue because she was the on-coming nurse. She said the standard policy had always been to refill medications five days ahead of the last dose. In a telephone interview with LVN A on [DATE] at 1:50 p.m., she stated when she worked at the facility on [DATE], she spoke with Resident #1 and she could tell she had Tardive Dyskinesia because of her leg movements and tongue smacking. She said that was the first time she worked with Resident #1. She said Resident #1 said she had not received her medication in ,d+[DATE] days. She said she looked in the computer system to order it, but she could not find information on the specialty pharmacy. She said she called the DON to inform her about the issue. LVN A said she did not see any note on Resident #1's MAR to call the Social Worker about the medication, but on [DATE], the medication was already out. In a telephone interview with Resident #1's doctor on [DATE] at 2:15 p.m., he stated he was informed about the problem with Resident #1's Ingrezza on Tuesday ([DATE]). He said the medication was used to control Resident #1's involuntary movements. He said he immediately called the specialty pharmacy and spoke with the pharmacist, who assured him the medication would be shipped the same day. He said the pharmacist was aware they (the pharmacy) were awaiting a call from him (the doctor). He said he was not informed the pharmacy was trying to reach another doctor. An unsuccessful attempt was made to contact LVN C by phone on [DATE] at 2:45 p.m. LVN C returned the phone call on [DATE] at 12:17 p.m. and stated she worked with Resident #1 on Sunday ([DATE]) and Monday ([DATE]) on the 2:00 p.m. - 10:00 p.m. shift. She said the nurse from the previous shift (she could not recall the nurse's name) told her about the situation with Resident #1's medication. She said when she looked in the computer system, it showed the medication was ordered from the regular pharmacy, but Resident #1 said the medication had to be ordered from a specialty pharmacy. She said she did not see a note on Resident #1's MAR to contact the Social Worker, but she did see that note on the 24-hour report (the nurse on a previous shift documented to call the Social Worker on the 24-hour report). Record review of, Medication and Treatment Orders, revised [DATE] revealed, Policy Statement, Orders for medications and treatments will be consistent with principles of safe and effective order writing. Policy Interpretation and Implementation . 11. Drugs and biologicals that are required to be refilled must be ordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	Record review of, Abuse, Neglect, Exploitation, and Misappropriation of Property Prevention, Protection and Response Policy and Procedures, revised [DATE] revealed, . Neglect: The failure of the facility, its employees or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of patient care and services to assure that care is provided as needed by the patient .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 6 residents (Resident #1) reviewed for medications. Resident #1 experienced exacerbated symptoms of her illness with involuntary movements of her tongue and legs after she missed six doses of Ingrezza medication because the facility failed to order it before it ran out. This failure placed all residents whose medications were supervised by the facility at risk of experiencing serious side effects from possible interruptions to their medication regimen. Findings included: Record review of Resident #1's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with end-stage kidney disease (a medical condition in which a person's kidneys cease functioning), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), anemia (a condition in which the blood does not have enough healthy red blood cells), major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and osteoporosis (a condition in which bones become weak and brittle). Record review of Resident #1's MDS (Minimum Data Set), dated [DATE] revealed she had a BIMS (Brief Interview for Mental Status) of 15 (cognitively intact); she did not exhibit any symptoms of psychosis or behaviors; she required supervision and set-up assistance from staff for bed mobility, transfers, walking, dressing, eating, toilet use, and personal hygiene; she was independent with bathing; and she was always continent of bowel and bladder. Record review of Resident #1's care plan updated [DATE] revealed she was on sedative/hypnotic therapy; she used anti-anxiety medications; she used antidepressant medication; and she used antipsychotic medications (Goal: resident will be/remain free of psychotropic drug related complications, including movement disorder .), (Interventions: Administer Ingrezza for Tardive Dyskinesia [a condition affecting the nervous system, often caused by long-term use of some psychiatric drugs. Symptoms include repetitive, involuntary movements, such as grimacing, rapid blinking, tongue thrusting, lip smacking/puckering] .) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Observation and interview with Resident #1 on [DATE] at 12:40 p.m. revealed she was alert, oriented, and ambulated via wheelchair. Resident #1 stated she had not received her medication, Ingrezza, since the previous Monday, [DATE]. She stated she asked the nurses about the medication daily, but they always said it was coming tomorrow. She said the Ingrezza was for her Tardive Dyskinesia and since she had not received the medication, she noticed her tongue hung out of her mouth more, her legs went up and down involuntarily more and she did not sleep. She said these symptoms were very frustrating and she was upset because it would take some time for her body to adjust to the medication again. She said she had been up since 3:00 a.m. that day ([DATE]). She said nobody tried to order the medication until Sunday ([DATE]) and Monday ([DATE]) when they told her the pharmacy did not answer the phone. She said the medication came from a specialty pharmacy and nobody knew how to order it. Further observation of Resident #1 at that time revealed her tongue projected from her mouth at times while she talked and while at rest. Record review of Resident #1's, Medication Review Report (Physician's Orders) for [DATE] revealed: Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Notify SW when supply runs low at 8 doses left. Order Status: Discontinued (no date was listed), Order Date: [DATE], Start Date: [DATE]. Record review of Resident #1's, Medication Review Report (Physician's Orders) for [DATE] revealed: Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Call pharmacy for refills (pharmacy name and phone number). Order Status: Active, Order Date: [DATE], Start Date: [DATE]. Record review of Resident #1's MAR for [DATE] revealed: Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Notify SW when supply runs low at 8 doses left. Start Date: [DATE], D/C Date: [DATE]. Further review of the record revealed Ingrezza was administered daily in [DATE] until [DATE]. Doses were not administered [DATE] - [DATE]. Record review of Resident #1's MAR for [DATE] revealed: Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Notify SW when supply runs low at 8 doses left. Start Date: [DATE], D/C Date: [DATE]. Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia, Call pharmacy for refills (pharmacy name and phone number). Start Date: [DATE]. Further review of the record revealed the medication was not administered on [DATE]. Record review of Resident #1's Nursing Progress Notes for [DATE] revealed: On [DATE] at 8:38 p.m., LVN A wrote, Ingrezza Capsule 40 MG, Give 1 capsule by mouth at bedtime for Tardive Dyskinesia Notify SW when supply runs low at 8 doses left. Medication not available. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 6:27 p.m., LVN B wrote, MAR indicates Social Worker needs to be informed Eight (8) doses before the medication runs out to order it. Today is Saturday Weekend [DATE] (resident informed me she has missed 4 Evening doses - no orders noted to date). I will inform Social Worker at earliest convenience so medication could be ordered ASAP (Note: I was informed by Night Shift Nurse [night shift nurse was not named] that 1. Information for Specialty Pharmacy is on the order, but it is not, it shows old pharmacy information and 2. Social Worker needs to order it). On [DATE] at 6:46 a.m., LVN C wrote, Reported to DON about Ingrezza order needed via Social Worker thru a Specialty Pharmacy. DON will follow up. Day Shift Nurse informed/will monitor situation. On [DATE] at 10:24 a.m., the DON wrote, Spoke with specialty pharmacy and the order for the Ingrezza Capsule 40 MG was called in and the medication will be sent out today and will be delivered tomorrow. In an interview with the DON on [DATE] at 10:30 a.m., she said the facility had trouble getting Resident #1's Ingrezza, which had to be ordered through a specialty pharmacy. She said communication between the facility and the pharmacy was not effective. The DON said once she found out over the weekend ([DATE]) that the medication was not available in the facility, she contacted the specialty pharmacy who said they were trying to get the refill order from a doctor who no longer saw residents at the facility. The DON said she had to wait until Tuesday, [DATE], to call the specialty pharmacy because Monday, [DATE] was a holiday and the pharmacy was closed. She said she contacted the current doctor to refill the medication. She said medication refills should be requested within seven days before they ran out, but none of the nurses ever reported any problems with getting the medication within the seven days. She said regular medications were refilled through their computer system, but since the Ingrezza had to be ordered from a specialty pharmacy, the nurses may not have known how to order it. She said most of the nurses on the 2:00 p.m. - 10:00 p.m. shift (Resident #1 received the Ingrezza during this shift) were agency staff. In an interview with the Social Worker on [DATE] at 11:00 a.m., she stated she was not sure why there was a note to contact her about Resident #1's medication refill. She said she was the one who figured out which pharmacy to order the medication from back in [DATE] (when Resident #1 started taking the medication), so maybe the nurses thought she was the one who had to order the medication. She said in [DATE], she called their regular pharmacy because they did not provide the Ingrezza and they told her the name of the specialty pharmacy who could provide the medication. She said nobody ever notified her when Resident #1 had eight doses of the Ingrezza left, or when it ran out. She said she was not made aware when the nurses had issues with the medication refill. In an interview with the Administrator on [DATE] at 1:00 p.m., he said he was aware of Resident #1's medication situation. He said one of agency nurses must have put the note in Resident #1's MAR to contact the Social Worker about ordering the medication, but that was not correct. He said the facility's policy was to re-order medications within three days of last dose, but if the medication was hard to get, the nurses should have written a special note on the MAR to try and re-order more than three days ahead. He said he was not aware of any side effects Resident #1 had experienced due to not having her medication. He said even when Resident #1 received the medication daily, she still had some signs of it the Tardive Dyskinesia. He stated he observed and talked to Resident #1 while passing through the hallways and he did not notice anything unusual. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

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 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview with the DON on [DATE] at 1:15 p.m., she said Resident #1's doctor never stopped seeing residents at the facility, but his NP stopped seeing residents in [DATE]. She said when she found out about the issue on Saturday ([DATE]), she told LVN C to look for any notes from the Social Worker to find the specialty pharmacy's phone number, but LVN C said she could not find it. The DON said she found the name and phone number for the specialty pharmacy, but there was no answer after hours on a Saturday ([DATE]). She said she tried again on Sunday ([DATE]) and Monday ([DATE]) but there was no answer. She said when she called the specialty pharmacy on Tuesday ([DATE]), the representative said Resident #1's prescription was expired and a new order had to be submitted. She said the representative said the pharmacy had been trying to reach the old NP, but they could not reach her. The DON said she called Resident #1's doctor and he wrote a new order. She said she tried to get an order from Resident #1's primary doctor, but they could not write the order because the medication was referred by the psychiatrist. The DON stated the Ingrezza was delivered by the specialty pharmacy 20 minutes ago (on [DATE] 20 minutes prior to the interview) and would be administered to Resident #1 that evening. The DON said she deleted the note on Resident #1's MAR to contact the Social Worker (that was why the initial order for Ingrezza was discontinued on [DATE] and a new order was created on the same day) and instead, wrote the name and phone number of the specialty pharmacy on the MAR. She said she did not know why the nurses did not contact the Social Worker eight days ahead, as the note instructed. She said the nurses did call her, but not eight days before the medication ran out. She said if Resident #1 was out of her medication since last Monday ([DATE]), she (Resident #1) would have found her (the DON) and hounded (harassed) her until the medication was in because that is what she normally did whenever she felt her medications were low. She said most of the 2:00 p.m. - 10:00 p.m. shift were agency nurses, but the facility tried to staff the same nurses who were familiar with their processes. She said they provided an orientation for all agency nurses and gave them her phone number to call with any questions. The DON said her expectation was for the agency nurses to call the Social Worker because that was what the order said. She said the next thing for them to do would have been to follow the chain of command and call her (the DON) or the ADON and bring the issue to their attention sooner. The DON said Resident #1 told her she needed the medication because her tongue and legs were moving more, but she (the DON) did not observe anything unusual about Resident #1. She said although she could not see anything different, maybe Resident #1 could see and feel the difference. In a telephone interview with LVN B on [DATE] at 1:35 p.m., she said she worked on Saturday ([DATE]) and Resident #1 said she had not received the Ingrezza for the last four nights. She said she looked at Resident #1's MAR and noted the last time the medication was ordered was sometime in [DATE]. She said she saw the note to inform the Social Worker eight doses ahead on Saturday ([DATE]), but she did not see the note before then. She said she called the regular pharmacy because they were the last to fill the order, but they said it had to be filled by a specialty pharmacy because they no longer supplied it. She said he called the DON, who said she would follow up. LVN B said she was familiar with Resident #1 because she had previously cared for her. She said she observed that Resident #1's tongue was doing something a little unusual. She said Resident #1 asked her if she saw anything unusual about her tongue, but she did not want to alarm her, so she said she did not see anything different. She said she told LVN C about the issue because she was the on-coming nurse. She said the standard policy had always been to refill medications five days ahead of the last dose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	06/02/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview with LVN A on [DATE] at 1:50 p.m., she stated when she worked at the facility on [DATE], she spoke with Resident #1 and she could tell she had Tardive Dyskinesia because of her leg movements and tongue smacking. She said that was the first time she worked with Resident #1. She said Resident #1 said she had not received her medication in ,d+[DATE] days. She said she looked in the computer system to order it, but she could not find information on the specialty pharmacy. She said she called the DON to inform her about the issue. LVN A said she did not see any note on Resident #1's MAR to call the Social Worker about the medication, but on [DATE], the medication was already out. In a telephone interview with Resident #1's doctor on [DATE] at 2:15 p.m., he stated he was informed about the problem with Resident #1's Ingrezza on Tuesday ([DATE]). He said the medication was used to control Resident #1's involuntary movements. He said he immediately called the specialty pharmacy and spoke with the pharmacist, who assured him the medication would be shipped the same day. He said the pharmacist was aware they (the pharmacy) were awaiting a call from him (the doctor). He said he was not informed the pharmacy was trying to reach another doctor. An unsuccessful attempt was made to contact LVN C by phone on [DATE] at 2:45 p.m. LVN C returned the phone call on [DATE] at 12:17 p.m. and stated she worked with Resident #1 on Sunday ([DATE]) and Monday ([DATE]) on the 2:00 p.m. - 10:00 p.m. shift. She said the nurse from the previous shift (she could not recall the nurse's name) told her about the situation with Resident #1's medication. She said when she looked in the computer system, it showed the medication was ordered from the regular pharmacy, but Resident #1 said the medication had to be ordered from a specialty pharmacy. She said she did not see a note on Resident #1's MAR to contact the Social Worker, but she did see that note on the 24-hour report (the nurse on a previous shift documented to call the Social Worker on the 24-hour report). Record review of, Medication and Treatment Orders, revised [DATE] revealed, Policy Statement, Orders for medications and treatments will be consistent with principles of safe and effective order writing. Policy Interpretation and Implementation . 11. Drugs and biologicals that are required to be refilled must be ordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available .