STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455565	A. Building B. Wing	01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36491 580 Based on record review and interviews, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) of a medication error for 1 of 4 residents (Resident #1) reviewed for resident rights. The facility failed to inform the Physician, NP, or DON when Resident #1 received the wrong medications on 1/4/2023. This failure resulted in identification of Immediate Jeopardy (IJ) on 1/9/2023 at 4:20 p.m. The IJ was removed on 1/10/2023 at 11:47 a.m. While the IJ was removed, the facility remained out of compliance at a scope of isolated and a severity level of actual harm that is not immediate, due to the facility's need to complete in-servicing and monitoring interventions. This failure could place residents at risk not receiving appropriate care and interventions and/or death. Findings included: Record review of Resident #2's Face Sheet dated January 2022 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE], with a recent readmitted [DATE]. Resident #2's diagnoses included schizoaffective disorder bipolar type, (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior)., major depressive disorder, and human immunodeficiency virus (a virus that attacks the body's immune system.) Record review of Resident #2's Physician orders dated January 2022 indicated the following medications were to be administered daily to Resident #2 between 7:30 p.m. and 10:00 p.m. Cogentin 1 mg- used to treat symptoms of Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs Prolixin 10 mg- used to treat certain types of mental/mood conditions: (psychotic disorders; schizophrenia) (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Haldol 5 mg- used to treat certain types of mental/mood conditions: schizophrenia, schizoaffective Isentress 400 mg- used to treat human immunodeficiency virus infections Toprol 25 mg- used to treat symptoms used to treat chest pain, heart failure and high blood pressure Seroquel 500 mg- used to treat certain types of mental/mood conditions: Schizophrenia, Bipolar disorder, sudden episodes of mania or depression associated with Bipolar Disorder Risperdal 3 mg- used to treat certain types of mental/mood disorders; Schizophrenia, Bipolar, irritability associated with autistic disorder Glucophage 1000 mg- used to control blood sugar Eskalith 300 mg- mood stabilizer used to treat or control the manic episodes of Bipolar disorder (manic depression) Record review of Resident #1's Face Sheet dated January 2023 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE], with a recent readmitted [DATE]. Resident #1's diagnoses included polyosteoarthritis, (when five or more joints are affected with joint pain), unspecified intellectual disabilities, (when a person has certain limitations in cognitive functioning and skills, including communication, social and self-care skills), diabetes (a chronic (long-lasting) health condition that affects how your body turns food into energy), bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania and lows (depression), epilepsy, (a brain disorder that causes recurring, unprovoked seizures.), hypertension (when blood pressure is too high), and peripheral vascular disease (a slow and progressive circulation disorder). Record review of Resident #1's MDS dated [DATE] reflected a BIMS score of 9 for cognitive awareness, which indicated she was moderately impaired. The MDS indicated Resident #1 required supervision with set up assistance for transfers, walking in the room or corridor, dressing, eating, toileting, and personal hygiene. Record review of a Facility Event Report dated 1/5/2023 at 9:36 p.m. indicated on 1/4/2023 Resident #1 was given the wrong medications. Resident #1 was sent to the ER. Record review of the nursing progress notes for Resident #1 revealed there were no entries documented on 1/4 or 1/5 2023 by RN A. Record review of a nursing progress note written by LVN B and dated 1/5/2023 at 10:34 a.m. indicated Resident #1 was lying in bed, appeared to be lethargic (lacking mental and physical alertness and activity). with limited speech, and non-reactive pupils. Resident #1 had to have more help than normal. Her BP was 121/63. The Nurse Practitioner was notified and ordered Resident #1 to be sent to the ER for evaluation and treatment. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a nursing progress note written by LVN C dated 1/6/2023 at 3:48 p.m. indicated Resident #1 returned to from the ER related to altered mental status. Resident #1's diagnoses included a UTI and dehydration. Resident #1's mood was pleasant. The NP was notified. Record review of a nursing progress note written by LVN D dated 1/6/2023 at 10:.00 p.m. indicated Resident #1's orientation was within normal baseline with a slightly unsteady gait. Record review of Resident #1's Medication Administration Record dated 1/1/2023-1/7/2023 indicated the following medications were to be administered daily to Resident #1 between 7:30 p.m. and 10:00 p.m. Claritin 10 mg- an antihistamine that treats symptoms such as itching, runny nose, watery eyes, and sneezing from hay fever and other allergies Depakote 500 mg- used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder) Keppra 1,000 mg- used to treat certain types of seizures Lorazepam 1mg- used to treat anxiety Magnesium 400 mg- used to treat vitamin D deficiency Metformin 500 mg-used to control high blood sugar Vimpat 100 mg- used to prevent and control seizures RN A signed off the medications as being given to Resident #1 on 1/4/2023. Record review of #1's Hospital Discharge Summary dated 1/6/2023 revealed Resident #1 was admitted on [DATE] and discharged back to nursing facility 1/6/2023. Discharge diagnoses included acute urinary tract infection, acute renal failure syndrome (sudden and sustained deterioration of the kidney function) and altered mental status. Hospital course reflected: On 1/6/2023 in discussion with family members it was revealed the patient was given up to 6 medications that were belonging to the patient's neighbor (Resident #2), with most of them being psychiatric with a heavily sedating effect. Upon evaluation in the morning, patient was found alert and orient x3, answering questions appropriately, speaking in full sentences, minimal confusion/disorientation noted in the early morning hours which resolved by the afternoon. Deemed stable for discharge. The hospital record indicated a drug screen was done on 1/5/2023 at 11:10 a.m. The results reflected the resident was negative for methadone, cocaine, THC (psychoactive component in marijuana), barbiturates, benzodiazepines, opiates, amphetamines, and PCP, (Phencyclidine, a sedative narcotic). Record review of a facility Event Report dated 1/5/23 at 9:36 p.m. indicated on 1/4/2023 Resident #1 was given the wrong medications. Resident was sent to the ER. Record review of a Facility Event Summary Report dated from 8/1/2022 to 1/9/20233 indicated that the facility had 1 reported medication error during this period, with date of occurrence 1/4/2023. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/7/2023 at 10:37 a.m. the ADON said RN A worked the 6 p.m.-6 a.m. shift on 1/4/2022. The ADON said RN A did not report the med error until she came to work on 1/5/2022 for her 6 p. m.-6 a.m. shift and found out Resident #1 had been sent to the hospital. The ADON said RN A had 2 med cups with pills, one for Resident #1 and one for Resident #2, who were roommates. The ADON said RN A realized at some point she had given the wrong medicine to Resident #1, which actually belonged to Resident #2. The ADON said the DON was notified at some time around 9:33 p.m. on 1/5/2023. The ADON said Resident #1 usually questioned her meds before taking them. During an interview on 1/7/2023 12:30 p.m. Resident #1 said she was doing well. Resident #1 stated she had returned from the hospital 1/6/2023 and went to the hospital because of too much sugar, and my sugar was high. All the candy I ate at Christmas made my sugars go up, is what the doctor told me. Resident #1 said she took medications in the morning and in the evening and had never had any problems getting the right ones. During an interview on 1/7/2023 12:34 p.m. Resident #2 stated she received medications in the morning and in the evening. Resident #2 said she had problems 2 different times getting the right medications. Resident #2 said she received meds on 1/4/2023, and when she looked at them, she asked the nurse what they were, as they did not look right. Resident #2 said she could not pinpoint the time frame for the first event, but said it was the same nurse, RN A. Resident #2 said RN A gave her meds to her roommate and that was why she went to the hospital. Resident #2 said she did not take any of the meds that were not hers. Resident #2 said RN A was nice and told her she was daydreaming when she was giving the meds. Resident #2 said her roommate is confused at times. During an interview on 1/7/2023 12:40 p.m. the RNC said she was aware of the medication error on 1/4/2022. The RNC said training was started immediately, and that RN A would be called in on this date and suspended until the investigation was completed. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/7/2023 1:45 p.m. RN A stated on 1/4/2022, 6 p.m.-6 a.m. shift she was getting ready to give meds to both Resident #1 and Resident #2. RN A said she got 2 med cups out, filled 1 cup with medications and scooted it back under the computer, filled the other med cup with medications and scooted it back as well. RN A said she went into Resident #1's room, called her name and told her she had her meds. RN A said Resident #1 sat up in bed and she gave Resident #1 the med cup. RN A said Resident #1 looked at the pills and took them. RN A said she walked out of the room and got distracted. RN A said on the evening shift, they were the secretary, they had to answer phones, and the door, and answer call lights so it was 1-2 hours before she went back to give Resident #2 her meds. RN A said she grabbed the other cup of pills that were locked in the med cart, in the same cup she had previously filled. RN A said she handed Resident #2 the cup and Resident #2 looked at the pills said, These don't look right. RN A said she immediately thought oh no what did I do?. RN A said she and Resident #2 went to the med cart. RN A said she looked at the cup and knew she had just given Resident #1 Resident #2's meds. She said she told the resident she did not know what had happened, but she was going to get rid of the meds and start over. RN A said she poured new meds and gave them to Resident #2. RN A said she realized she gave the wrong meds to Resident #1, when Resident #2 said her pills did not look right. RN A stated she did not do what she should have; she should have called the doctor but did not because Resident #1 slept all night. RN A said the next day, 1/5/2023 around 6:30 p.m. she returned to work and saw that Resident #1 had been sent to the hospital. The DON was in the building, and RN A told her what she had done, and was told to complete an incident report. RN A said she probably passed meds to 4-5 residents prior to the incident involving Resident #1 but did not remember for sure. RN A said she did not give any more meds after the incident. RN A said Resident #1 slept all night with no issues noted. RN A said she did not normally fill 2 med cups at one time and had every intention of going back to give Resident #2's meds sooner. RN A said she did not put the residents' names on the medication cups. RN A said she had not made this mistake before, and no other resident had looked at their pills prior to taking them and stated they were the wrong medications. During an interview on 1/9/2023 at 10:22 a.m. LVN B stated she worked the 6:00 a.m.-6:00 p.m. LVN B stated on 1/5/2023 she went into Resident #1's room either during or after breakfast. LVN B stated Resident #2 said she had to help Resident #1 from the bathroom. LVN B stated Resident #1 was lying in her bed. LVN B called Resident #1 by her name and Resident #1 said huh? and nothing else. LVN B stated Resident #1 seemed lethargic. LVN B stated she got the DON and they did an assessment and Resident #1's blood pressure was 103 over something but could not remember exactly but said it was low. LVN B stated a neuro exam was done, and Resident #1's pupils were not reactive. LVN B stated she notified the NP and an order was received to transfer Resident #1 to the hospital. LVN B stated Resident #1 was admitted to the hospital with altered mental status diagnosis. LVN B said she was off the next 3 days and was unsure what all had transpired. LVN B said she passed medications in the morning and had a couple in the afternoon. LVN B said when passing meds, she addressed the resident by name, checked vital signs, pulled medications, and went in the room to administer them. LVN B said on the computer system there was a picture of each resident. She said she also verified the resident by the name on the door, and by addressing them by name. LVN B stated when she put meds in the med cup, there was a place on the electronic medication record to put a check mark by the medication to keep track of what has been put in med cup. LVN B stated she did not click on the given button until the resident had taken the medication in case they refused or were unable to take it for some reason. LVN B stated she only dispensed medications for 1 resident at a time. LVN B stated if she would happen to give the wrong medication to a resident, she would immediately notify the Dr., NP., Administrator and DON. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/9/2023 at 1:57 p.m. The NP stated she had been made aware of the medication error on Resident #1 on 1/5/2022. The NP said there was no harm, no lingering side effects, or no treatments/testing that would be necessary. The NP said she had asked the staff to monitor Resident #1's vital signs and report any changes. The NP said there were no issues with Resident #1 not receiving the actual medications she was prescribed, as they were just 1 series of doses. The NP stated that RN A was not following policies, the right patient, the right med, the right dose. The NP felt RN A needed remediation and reported to the Board of Nursing. Record review of the facility policy Adverse Consequences and Medication Errors, with a revision date of April 2014 indicated, a medication error is defined as the preparation of administration of drugs which are not in accordance with physician orders . In the event of a significant medication related error or adverse consequence, immediate action is taken, as necessary to protect the resident's safety and welfare. Significant is defined as requiring hospitalization . The attending physician is notified promptly of any significant error or adverse consequence. The Plan of Removal was accepted on 9:15 a.m. on 1/10/2023, and included the following: Plan of Removal F760 Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on 1/9/23, for F760 Free of Significant Med Error Action Item: The resident was sent to Hospital on 1/5/23 for assessment. Person Responsible: DON Timeline for completion: 1/10/23 Action Item: Medication administration records were reviewed for all other residents with no other errors identified. Person Responsible: RN Regional Nurse Consultant Timeline for completion: 1/10/23 Action Item: Medication administration training, education and competencies including Medication Administration Policies, Adverse Consequences and Medication Errors, Notification of med error to DON/Physician and med error investigations were completed with the nurses on 1/9/23 by the Regional Nurse Consultant. New nursing staff will complete competency prior to working the floor. Person Responsible: Nursing and administration Timeline for completion: 1/10/23 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action Item: medication administration observations will be completed on weekly basis for all shifts until substantial compliance has been achieved. Person Responsible: DON Timeline for completion: 1/10/23 Verification of the Plan of Removal was as follows: a. Reviewed in-service training on 1/7/23 and 1/10/23 for all nursing staff, on all shifts. The nursing staff were in-serviced on medication administration, error prevention, medication administration policies reviewed. Guidelines for notifying physicians for clinical problems, as well as notifying the NP, and DON. b. Competency Assessment/skills check off for Administering Oral medications was initiated, for all nursing staff, on all shifts. Six had been completed. c. Interviews conducted 1/10/2023 between 11:25 a.m. and 11:43 a.m. revealed LVNs B, F, and G all stated they worked the 6:00 a.m.-6:00 p.m. shift, and had received in-servicing provided by the facility as part of the plan of removal and all had knowledge and understanding of reporting med errors immediately and the proper procedure for medication administration, and proper resident identification. An Immediate Jeopardy (IJ) was identified on 1/9/2023 at 4:20 p.m. The IJ was removed on 1/10/2023 at 11:47 a.m. While the IJ was removed, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with a potential for more than minimal harm due to the facility's need to complete in-servicing and monitoring interventions.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36491 760 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 4 residents reviewed for pharmacy services. (Resident #1) RN A administered Resident #2's medication to Resident #1, resulting in Resident #1 experiencing an altered mental status requiring transfer to local hospital for evaluation. This failure resulted in identification of Immediate Jeopardy (IJ) on 1/9/2023 at 4:20 p.m. The IJ was removed on 1/10/2023 at 11:47 a.m. While the IJ was removed, the facility remained out of compliance at a scope of isolated and a severity level of actual harm that is not immediate, due to the facility's need to complete in-servicing and monitoring interventions. This failure could place residents at risk for a serious decline in health, hospitalization and/or death. Findings included: Record review of Resident #2's Face Sheet dated January 2022 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE], with a recent readmitted [DATE]. Resident #2's diagnoses included schizoaffective disorder bipolar type, (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior)., major depressive disorder, and human immunodeficiency virus (a virus that attacks the body's immune system.) Record review of Resident #2's Physician orders dated January 2022 indicated the following medications were to be administered daily to Resident #2 between 7:30 p.m. and 10:00 p.m. Cogentin 1 mg- used to treat symptoms of Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs Prolixin 10 mg- used to treat certain types of mental/mood conditions: (psychotic disorders; schizophrenia) Haldol 5 mg- used to treat certain types of mental/mood conditions: schizophrenia, schizoaffective Isentress 400 mg- used to treat human immunodeficiency virus infections Toprol 25 mg- used to treat symptoms used to treat chest pain, heart failure and high blood pressure Seroquel 500 mg- used to treat certain types of mental/mood conditions: Schizophrenia, Bipolar disorder, sudden episodes of mania or depression associated with Bipolar Disorder (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Risperdal 3 mg- used to treat certain types of mental/mood disorders; Schizophrenia, Bipolar, irritability associated with autistic disorder Glucophage 1000 mg- used to control blood sugar Eskalith 300 mg- mood stabilizer used to treat or control the manic episodes of Bipolar disorder (manic depression) Record review of Resident #1's Face Sheet dated January 2022 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE], with a recent readmitted [DATE]. Resident #1's diagnoses included polyosteoarthritis, (when five or more joints are affected with joint pain), unspecified intellectual disabilities, (when a person has certain limitations in cognitive functioning and skills, including communication, social and self-care skills), diabetes (a chronic (long-lasting) health condition that affects how your body turns food into energy), bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania and lows (depression), epilepsy, (a brain disorder that causes recurring, unprovoked seizures.), hypertension (when blood pressure is too high), and peripheral vascular disease (a slow and progressive circulation disorder). Record review of Resident #1's MDS dated [DATE] reflected a BIMS score of 9 for cognitive awareness, which indicated she was moderately impaired. The MDS indicated Resident #1 required supervision with set up assistance for transfers, walking in the room or corridor, dressing, eating, toileting, and personal hygiene. Record review of a Facility Event Report dated 1/5/2023 at 9:36 p.m. indicated on 1/4/2023 Resident #1 was given the wrong medications. Resident #1 was sent to the ER. Record review of the nursing progress notes for Resident #1 revealed there were no entries documented on 1/4 or 1/5 2023 by RN A. Record review of a nursing progress note written by LVN B and dated 1/5/2023 at 10:34 a.m. indicated Resident #1 was lying in bed, appeared to be lethargic (lacking mental and physical alertness and activity). with limited speech, and non-reactive pupils. Resident #1 had to have more help than normal. Her BP was 121/63. The Nurse Practitioner was notified and ordered Resident #1 to be sent to the ER for evaluation and treatment. Record review of a nursing progress note written by LVN C dated 1/6/2023 at 3:48 p.m. indicated Resident #1 returned to from the ER related to altered mental status. Resident #1's diagnoses included a UTI and dehydration. Resident #1's mood was pleasant. The NP was notified. Record review of a nursing progress note written by LVN D dated 1/6/2023 at 10:.00 p.m. indicated Resident #1's orientation was within normal baseline with a slightly unsteady gait. Record review of Resident #1's Medication Administration Record dated 1/1/2023-1/7/2023 indicated the following medications were to be administered daily to Resident #1 between 7:30 p.m. and 10:00 p.m. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Claritin 10 mg- an antihistamine that treats symptoms such as itching, runny nose, watery eyes, and sneezing from hay fever and other allergies Depakote 500 mg- used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder) Keppra 1,000 mg- used to treat certain types of seizures Lorazepam 1mg- used to treat anxiety Magnesium 400 mg- used to treat vitamin D deficiency Metformin 500 mg-used to control high blood sugar Vimpat 100 mg- used to prevent and control seizures RN A signed the medications as being given to Resident #1 on 1/4/2023. Record review of #1's Hospital Discharge Summary dated 1/6/2023 revealed Resident #1 was admitted on [DATE] and discharged back to nursing facility 1/6/2023. Discharge diagnoses included acute urinary tract infection, acute renal failure syndrome (sudden and sustained deterioration of the kidney function) and altered mental status. Hospital course reflected: On 1/6/2023 in discussion with family members it was revealed the patient was given up to 6 medications that were belonging to the patient's neighbor (Resident #2), with most of them being psychiatric with a heavily sedating effect. Upon evaluation in the morning, patient was found alert and orient x3, answering questions appropriately, speaking in full sentences, minimal confusion/disorientation noted in the early morning hours which resolved by the afternoon. Deemed stable for discharge. The hospital record indicated a drug screen was done on 1/5/2023 at 11:10 a.m. The results reflected the resident was negative for methadone, cocaine, THC (psychoactive component in marijuana), barbiturates, benzodiazepines, opiates, amphetamines, and PCP, (Phencyclidine, a sedative narcotic). Record review of a written statement by RN A dated 1/7/2023 indicated the following: On 1/4/23 I mistakenly gave the wrong medications to Resident #1. I was not alerted till I went to give meds to the roommate, and she stated she did not recognize her meds in the cup I gave her. So, I destroyed the meds and repoured in front of the patient and gave her meds at the med cart. I did not notify DON/ADON at this time. Record review of RN A's disciplinary record dated 1/7/2023 indicated the date of violation was 1/4/2023. The rule infracted was medications being given to the wrong resident. RN A was suspended pending an investigation. During an interview on 1/7/2023 at 10:37 a.m. the ADON said RN A worked the 6 p.m.-6 a.m. shift on 1/4/2022. The ADON said RN A did not report the med error until she came to work on 1/5/2022 for her 6 p.m.-6 a.m. shift and found out Resident #1 had been sent to the hospital. The ADON said RN A had 2 med cups with pills, one for Resident #1 and one for Resident #2, who were roommates. The ADON said RN A realized at some point she had given the wrong medicine to Resident #1, which actually belonged to Resident #2. The ADON said the DON was notified at some time around 9:33 p.m. on 1/5/2023. The ADON said Resident #1 usually questioned her meds before taking them. (continued on next page)

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	455565	A. Building B. Wing	01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/7/2023 12:30 p.m. Resident #1 said she was doing well. Resident #1 stated she had returned from the hospital 1/6/2023 and went to the hospital because of too much sugar, and my sugar was high. All the candy I ate at Christmas made my sugars go up, is what the doctor told me. Resident #1 said she took medications in the morning and in the evening and had never had any problems getting the right ones. During an interview on 1/7/2023 12:34 p.m. Resident #2 stated she received medications in the morning and in the evening. Resident #2 said she had problems 2 different times getting the right medications. Resident #2 said she received meds on 1/4/2023, and when she looked at them, she asked the nurse what they were, as they did not look right. Resident #2 said she could not pinpoint the time frame for the first event, but said it was the same nurse, RN A. Resident #2 said RN A gave her meds to her roommate and that was why she went to the hospital. Resident #2 said she did not take any of the meds that were not hers. Resident #2 said RN A was nice and told her she was daydreaming when she was giving the meds. Resident #2 said her roommate is confused at times. During an interview on 1/7/2023 12:40 p.m. the RNC said she was aware of the medication error on 1/4/2022. The RNC said training was started immediately, and that RN A would be called in on this date and suspended until the investigation was completed. During an interview on 1/7/2023 1:45 p.m. RN A stated on 1/4/2022, 6 p.m.-6 a.m. shift she was getting ready to give meds to both Resident #1 and Resident #2. RN A said she got 2 med cups out, filled 1 cup with medications and scooted it back under the computer, filled the other med cup with medications and scooted it back as well. RN A said she went into Resident #1's room, called her name and told her she had her meds. RN A said Resident #1 sat up in bed and she gave Resident #1 the med cup. RN A said Resident #1 looked at the pills and took them. RN A said she walked out of the room and got distracted. RN A said on the evening shift, they were the secretary, they had to answer phones, and the door, and answer call lights so it was 1-2 hours before she went back to give Resident #2 her meds. RN A said she grabbed the other cup of pills that were locked in the med cart, in the same cup she had previously filled. RN A said she handed Resident #2 the cup and Resident #2 looked at the pills said, These don't look right. RN A said she immediately thought oh no what did I do?. RN A said she and Resident #2 went to the med cart. RN A said she looked at the cup and knew she had just given Resident #1 Resident #2's meds. She said she told the resident she did not know what had happened, but she was going to get rid of the meds and start over. RN A said she poured new meds and gave them to Resident #2. RN A said she realized she gave the wrong meds to Resident #1, when Resident #2 said her pills did not look right. RN A stated she did not do what she should have; she should have called the doctor but did not because Resident #1 slept all night. RN A said the next day, 1/5/2023 around 6:30 p.m. she returned to work and saw that Resident #1 had been sent to the hospital. The DON was in the building, and RN A told her what she had done, and was told to complete an incident report. RN A said she probably passed meds to 4-5 residents prior to the incident involving Resident #1 but did not remember for sure. RN A said she did not give any more meds after the incident. RN A said Resident #1 slept all night with no issues noted. RN A said she did not normally fill 2 med cups at one time and had every intention of going back to give Resident #2's meds sooner. RN A said she did not put the residents' names on the medication cups. RN A said she had not made this mistake before, and no other resident had looked at their pills prior to taking them and stated they were the wrong medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/9/2023 at 9:35 a.m. the DON stated that on 1/4/2023, RN A did not say anything to her about a medication error. The DON stated on the morning of 1/5/2023 LVN B told her Resident #1 was not looking like herself. The DON stated Resident #1's blood pressure was low (could not remember exactly what it was) and her heart rate went from 60 to 40 beats per minute when aroused. The DON said neuro checks were done and Residents #1's pupils were pinpoint and fixed. The DON said Resident #1 went out to the hospital. The DON said she had called the hospital around 10:00 a.m., and the hospital did not have an update at that time. The DON said the hospital called back later in the day on 1/5/2023 saying Resident #1 was diagnosed with a drug overdose. The DON said she immediately looked at her meds and was puzzled all day, as to what medications Resident #1 had taken to cause a drug overdose. The DON said the hospital did not tell her what, if anything tested positive on the drug screen, or confirm a specific drug. The DON stated the hospital thought it was an overdose based on Resident #1's symptoms of being lethargic. The DON stated Resident #1 was diagnosed with a UTI and encephalopathy (brain disease, damage, or malfunction). The DON said RN A came back to work on 1/5/2023 6p.m.-6a.m. shift. The DON said when RN A saw that Resident #1 was sent to the hospital, she came into her office and said, I think I gave [Resident #2's] medications to [Resident #1]. The DON stated RN A was asked why she was just now reporting it, and never said anything before. The DON said RN A said, I wasn't going to say anything. DON stated she asked RN A why, and RN A said, I don't know. The DON stated RN A said she had 2 med cups of meds, and she gave Resident #1 medications, and when she went to give her roommate, Resident #2, her meds, Resident #2 said the pills were not her medications. The DON stated RN A said she did not give Resident #1 her correct medications, and she had clicked the given button before any meds were given, so the medication administration record reflected the medications Resident #1 was supposed to be given, were not. The DON stated after RN A reported this information to her on 1/5/2023, she notified the Administrator, the RNC, and the NP. The DON stated on 1/6/2022 when Resident #1 returned from the hospital, she was alert and oriented, as she was prior to the event. The DON said she talked to Resident #1 and asked her why she did not look at her meds before taking them, as she usually did. The DON said Resident #1 stated, I was already in bed, and I trusted her. The DON sated Resident #1 said she did not want to get RN A in trouble. The DON stated RN A said after the incident she did not have any more medications to pass. The DON stated RN A should not have signed the medications as being given until after they were administered. The DON stated RN A should only pass medications to 1 resident at a time, according to best practices. She stated RN A should have reported the incident immediately even if she wasn't sure she had made a mistake so Resident #1 could have been sent out for any possible adverse drug reactions. The DON stated she had started in-service training on medication pass, identifying and reporting med errors when she found out the medication error had occurred on 1/5/2023. DON stated she planned to do competency check offs on all nursing staff this week. She stated she also asked staff to do a double check before passing any and all meds; to double check med orders and the right resident. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/9/2023 at 10:22 LVN B stated she worked the 6:00 a.m.-6:00 p.m. LVN B stated on 1/5/2023 she went into Resident #1's room either during or after breakfast. LVN B stated Resident #2 said she had to help Resident #1 from the bathroom. LVN B stated Resident #1 was lying in her bed. LVN B called Resident #1 by her name and Resident #1 said huh? and nothing else. LVN B stated Resident #1 seemed lethargic. LVN B stated she got the DON and they did an assessment and Resident #1's blood pressure was 103 over something but could not remember exactly but said it was low. LVN B stated a neuro exam was done, and Resident #1's pupils were not reactive. LVN B stated she notified the NP and an order was received to transfer Resident #1 to the hospital. LVN B stated Resident #1 was admitted to the hospital with altered mental status diagnosis. LVN B said she was off the next 3 days and was unsure what all had transpired. LVN B said she passed medications in the morning and had a couple in the afternoon. LVN B said when passing meds, she addressed the resident by name, checked vital signs, pulled medications, and went in the room to administer them. LVN B said on the computer system there was a picture of each resident. She said she also verified the resident by the name on the door, and by addressing them by name. LVN B stated when she put meds in the med cup, there was a place on the electronic medication record to put a check mark by the medication to keep track of what has been put in med cup. LVN B stated she did not click on the given button until the resident had taken the medication in case they refused or were unable to take it for some reason. LVN B stated she only dispensed medications for 1 resident at a time. LVN B stated if she would happen to give the wrong medication to a resident, she would immediately notify the Dr., NP., Administrator and DON. During an interview on 1/9/2023 at 10:41 a.m. the ADON said new employees spent 3 days with staff orienting on the med cart. The ADON said she frequently helped administer medications on the floor. The ADON said she looked at the residents' MAR, looked at the pills, and the label on them. The ADON said she made sure she had the right resident. The ADON said she would ask the resident their name if able, she looked at the name on the door, and the picture in Matrix (facility computer system) on the electronic MAR. The ADON stated she only filled meds for 1 resident at a time. She said she checked the residents' medications off by clicking on the prepare button as she put the medication in the pill cup but did not click the given button until after the resident took the meds. The ADON said all staff had been trained/or would be receiving training, including the Mobile Dispatch nurses (nurses working for an inner agency through the corporate office), on the process of reporting med errors, and medication administration. The ADON said RN A did not pay attention to what she was doing, and she did not report a possible med error which should have been reported immediately. During an interview on 1/9/2023 at 10:57 a.m. LVN E stated she usually worked the secured unit. LVN E said she had received training on medication administration/reporting errors. LVN E stated when she passed medications, she first cleaned the cart, then got ice or pudding to have available if needed. She stated she usually got the vital signs on all residents done first. LVN E stated she got medications together and would verify the resident by their picture in the computer. She stated she also asked the resident their name. She stated she would click the prep button and checks off the meds as she put them in the med cup. She stated she then would click the given button after the resident took their medications. LVN E stated if by chance she would give a wrong medication, she would immediately notify the physician, and DON. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/9/2023 at 1:57 p.m. the NP stated she had been made aware of the medication error involving Resident #1 on 1/5/2022. The NP said there was no harm, no lingering side effects, or no treatments/testing that would be necessary. The NP said she had asked the staff to monitor Resident #1's vital signs and report any changes. The NP said there were no issues with Resident #1 not receiving the actual medications she was prescribed, as they were just 1 series of doses. The NP stated RN A was not following policies regarding med pass which included the right patient, the right med, the right dose. Record Review of the facility policy Adverse Consequences and Medication Errors, with a revision date of April 2014 indicated, a medication error is defined as the preparation of administration of drugs which are not in accordance with physician orders . In the event of a significant medication related error or adverse consequence, immediate action is taken, as necessary to protect the resident's safety and welfare. Significant is defined as requiring hospitalization . The attending physician is notified promptly of any significant error or adverse consequence. Record Review of the facility policy Administering Medications, with a revision date of April 2019 indicated Medications are administered in a safe and timely manner as prescribed. Medication errors are document, reported, and reviewed . The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. The individual administering the medications verifies the resident's identity before giving the resident his/her medications . The individual administering the medication document in the resident's electronic record after administering the medication . The RDO, RNC, DON, and ADON were notified of an IJ on 1/9/2023 at 4:20 p.m. A copy of the IJ Template was emailed to the RDO and RNC 1/9/23 4:52 p.m. and a Plan of Removal was requested. The Plan of Removal was accepted on 9:15 a.m. on 1/10/2023, and included the following: Plan of Removal F760 Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on 1/9/23, for F760 Free of Significant Med Error Action Item: The resident was sent to Hospital on 1/5/23 for assessment. Person Responsible: DON Timeline for completion: 1/10/23 Action Item: Medication administration records were reviewed for all other residents with no other errors identified. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Person Responsible: RN Regional Nurse Consultant Timeline for completion: 1/10/23 Action Item: Medication administration training, education and competencies including Medication Administration Policies, Adverse Consequences and Medication Errors, Notification of med error to DON/Physician and med error investigations were completed with the nurses on 1/9/23 by the Regional Nurse Consultant. New nursing staff will complete competency prior to working the floor. Person Responsible: Nursing and administration Timeline for completion: 1/10/23 Action Item: medication administration observations will be completed on weekly basis for all shifts until substantial compliance has been achieved. Person Responsible: DON Timeline for completion: 1/10/23 Verification of the Plan of Removal was as follows: a. Reviewed in-service training on 1/7/23 and 1/10/23 for all nursing staff, on all shifts. The nursing staff were in-serviced on medication administration, error prevention, medication administration policies reviewed. Guidelines for notifying physicians for clinical problems, as well as notifying the NP, and DON. b. Competency Assessment/skills check off for Administering Oral medications was initiated, for all nursing staff, on all shifts. Six had been completed. c. Interviews conducted 1/10/2023 between 11:25 a.m. and 11:43 a.m. revealed LVNs B, F, and G said they worked the 6:00 a.m.-6:00 p.m. shift, and had received in-servicing provided by the facility as part of the plan of removal and all had knowledge and understanding of reporting med errors immediately and the proper procedure for medication administration, and proper resident identification. An Immediate Jeopardy (IJ) was identified on 1/9/2023 at 4:20 p.m. The IJ was removed on 1/10/2023 at 11:47 a.m. While the IJ was removed, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with a potential for more than minimal harm due to the facility's need to complete in-servicing and monitoring interventions.