STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675177	A. Building B. Wing	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	2711 Pine Tree Rd Longview, TX 75604

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 - Immediate jeopardy to resident health or safety 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** 36491 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, and administration of medications for 1 of 1 residents (Resident #1) reviewed for medication omission. 1. the facility failed to follow their protocol by failing to reorder a prescribed medication timely to prevent seizures, and Resident #1 missed two doses of medication, because his medication was not available and he had two back-to-back seizures and was taken to the hospital. (Clobazam (Onfi), used along with other medicines to treat seizures associated with Lennox-Gastaut syndrome, which is a severe condition characterized by repeated seizures (epilepsy) that begin early in life). 2. the facility did not reorder Resident #1's seizure medication until the day he went to the hospital and the facility did not notify his physician that he missed his medication. An IJ was identified on 5/17/23 at 2:30 p.m. The IJ was removed on 5/18/23 at 4:20 p.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 jeopardy due to the facility's need to monitor interventions and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of adverse medication effects and/or not receiving the therapeutic benefits of their medications, prescribed by the physician. Findings included: Record review of a face sheet dated 5/16/23 indicated Resident #1 was a [AGE] year-old male admitted to the facility 11/19/22 with diagnoses of epilepsy, unspecified intellectual disabilities, attention-deficit hyperactivity disorder, mild cognitive impairment of uncertain or unknown etiology, and presence of neurostimulator. Record review of an MDS assessment dated [DATE] indicated Resident #1 had moderate impaired cognition. He was independent with personal hygiene, and limited assistance with bathing. Record review of a care plan with a revision date of 03/08/23 indicated Resident #1 had a seizure disorder with an intervention to give seizure medication as ordered by the doctor. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Physician orders dated 4/25/23 indicated Resident #1 was to receive Onfi 20mg tablet, 1 tablet at bedtime for prevention of seizure. Record review of Medication Administration Record dated May 2023 indicated Onfi oral tablet 20 mg, give 1 tablet by mouth at bedtime. Last documented dose was given on 5/11/23. Record review of nurses notes dated 5/13/23 indicated CMA C documented medication (Onfi) is not in, and is not in the pyxis (a cart used to store medications). Nurse progress notes dated 5/14/23 at 6:00 a.m. written by LVN B indicated Resident #1 was transferred to the hospital related to having two seizures back-to-back. During an interview on 5/16/23 at 12:07 p.m. Resident #1 was in his room eating lunch. Resident #1 said he was treated well by staff, and all his needs were met. Resident #1 said he received his medications, but sometimes they were late because of the pharmacy, but he always received them. Resident #1 said he had to go to the hospital recently due to having a seizure, but did not remember too much about it, but said he thought he had taken his medications. During an interview on 5/16/23 at 12:15 p.m. the Administrator said on Friday 5/12/23 Resident #1 said he did not get his seizure medication at bedtime. Administrator said LVN A signed it off as being given but signed it off before discovering the medication was not in the facility. The Administrator said Resident #1's medication was not reordered and caused harm to the resident. During an interview on 5/16/23 at 1:32 p.m. the ADON said medications were to be reordered 5-7 days before the last dose of medication . Narcotics needed to be reordered 3-5 days before the last dose of medication. ADON said there had never been a previous problem with meds not being reordered. The ADON said any of the nurses who passed Resident #1's medications could have reordered the medication for it ran out. During an interview on 5/16/23 at 2:28 p.m. CMA C said she had been a med aide for 17-[AGE] years and worked the 2-10 shift. CMA C said on 5/13/23 she documented in Resident #1's progress notes that his Onfi was not in the facility. CMA C said she was told the medication had been reordered but could not remember who told her. CMA C said she told the nurse working (could not remember her name) to check and see if the medicine was in the pyxis). CMA C said she did not think missing 1 dose would cause a seizure and did not check to see if the medication had been reordered. CMA C said she was aware how important this medication was for the resident to receive. During a phone interview on 5/16/23 at 2:46 p.m. LVN A said that on 5/12/23, CMA C asked her to check the pyxis to check to see if the Onfi for Resident #1 was in it. LVN A looked and the medication was not in there. LVN A said she asked LVN H about the medication and was told if it is not in the cart, we don't have it. LVN A said she thought the medication had been reordered but did not check to see if it was. LVN A said on the MAR for Resident #1, on 5/12/23, she signed off that she had given the Onfi prior to discovering she did not have the medication. LVN A stated the Onfi was not given on 5/12/23. LVN A stated the physician and DON were not notified. LVN A said she was not aware of any other resident missing a dose of medicine. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/16/23 at 3:15 p.m. the DON and the Compliance Nurse said LVN A had been suspended pending investigation. DON said any of the staff passing Resident #1's medications could have reordered the medication. Compliance nurse and DON confirmed Resident #1 missed his dose of Onfi on 5/12/23 and 5/13/23. The DON confirmed the dose of Onfi on 5/12/23 was signed off as being given by LVN A but had not been given, as LVN A signed the medication off prior to realizing the medication was not available. DON said someone who had been passing his meds should have checked to see if the medication had been reordered as it was very important for the resident to receive it. During a phone interview on 5/16/23 at 3:45 p.m. LVN B was questioned about documenting a 1 which signified away from facility with meds, on the MAR on 5/14/2023 for Resident #1's dose of Onfi. LVN B said it was incorrect documentation. LVN B said it was Resident #1's roommate who was actually out of the facility. LVN B said she did not know why she clicked on it (the 1). LVN B said the medication was given, and she was aware of how important this medications was. During a phone interview on 5/17/23 at 12:31 p.m. the facility Medical Director said there was a small potential that missing 2 doses of Onfi could have caused Resident #1 to have a seizure but fairly unlikely. During a phone interview on 5/17/23 at 1:47 p.m. the Neurologist assistant stated the physician said, if Resident #1 had missed 2 doses of his Onfi, there was the potential of that causing him to have a seizure, but Resident #1 , had seizures so it was hard to say it was the cause, we will never know. The neurologist assistant said the emergency room physicians did not know Resident #1's history, and that the Neurologist had treated Resident #1 for years, and as long as Resident #1 was on his medication, he was good, and not worried about it. Assistant said labs are not drawn routinely as long as Resident #1 was stable. Record review of hospital records dated 5/16/23 revealed Resident #1 was admitted to the hospital on 5/14/23 at 6:35 a.m. Hospital physician documentation indicated the following: At this time it is my impression patient had a seizure from the abrupt discontinuation of clobazam (Onfi) which is a known complication. Diagnoses included seizure, volume depletion, electrolyte abnormality and withdrawal from clobazam. Resident #1 was discharged back to the nursing home on 5/14/2023 9:13 a.m. Record review of an Ordering Medications policy dated 2003 indicated the following: .reorder medication three to five days in advance of need to assure and adequate supply is on hand . An Immediate Jeopardy (IJ) was identified on 05/17/2023 at 2:30 p.m., due to the above failures. The Administrator was notified of the IJ, and the IJ template was provided on 5/17/2023 at 3:02 p.m. The Plan of removal was accepted on 5/18/2023 at 3:26 p.m., and included the following: 5/18/20224 Plan of Removal (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Problem: F755 Pharmacy Services Resident #1 was transferred to the hospital on 5/14/2023. Resident #1 returned to the facility on [DATE]. All medications ordered for Resident #1 were audited and verified that adequate supply is present. Audit completed by DON/ADON as of 5/17/2023. Onfi was reordered and administered for resident #1 on 5/14/2023. Administrator/Regional Compliance Nurse/ DON/ADON reviewed Medication Reorder policy and Medication administration policy as of 5/17/2023. DON or designee will review all orders daily to assure policies and procedures are being followed. Interventions: As of 5/17/2023, 100% audit was completed on all resident medications including anticonvulsants to ensure residents are receiving the physician ordered dose. The audit was completed by DON, ADON and Regional Compliance Nurse. No additional omissions were discovered. All resident medications including anticonvulsant medications were verified that they match the ordered dose as of 5/17/2023 by DON, ADON and Regional Compliance Nurse. All resident seizure orders match current physician orders. A Medication error completed as of 5/17/2023 by DON utilizing the medication error form. Pharmacy Consultant was notified of med error as of 5/17/2023 by DON. Ad hoc QAPI meeting was completed with MD and IDT team as of 5/17/2023 to review med error and root cause analysis, and plan of removal. The following in-services were initiated by the DON, ADON and Regional Nurse and completed as of 5/17/23 at 6pm. All Licensed Nurses or Certified Medication Aides not in serviced by 5/17/23 will be in-serviced prior to starting their next shift. In-services will be ongoing for all new hires before they assume their duties. The DON/ADON/Regional Nurse are responsible for conducting these in-services. Licensed Nurses will be in-serviced on: 5 Rights of Medication administration Reporting Medication error that has occurred or found immediately to Physician and DON Re-ordering medications timely to ensure a 5-7-day supply is present. Charge nurses and med aides are both responsible for the re-ordering of medications. Charge nurses will be responsible for auditing carts and reviewing medication supply with Medication Aides three times a week to ensure medications are ordered when needed. Medications need to be re-ordered as indicated on the medication card. The Charge nurse/Medication Aide will review the order status in PCC under the residents MAR for medications needing to be reordered and reorder if needed. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Notification of the MD and DON immediately for any resident medications that will not be administered as ordered. Certified Medication Aides will be in-serviced on: 5 Rights of Medication Administration Reporting Medication error that has occurred or found immediately to charge nurse and DON. Re-ordering medications timely to ensure a 5-7 day supply is present. Charge nurses and med aides are both responsible for the re-ordering of medications. Charge nurses will be responsible for auditing carts and reviewing medication supply with Medication Aides three times a week to ensure medications are ordered when needed. Medications need to be re-ordered as indicated on the medication card. The Charge nurse/Medication Aide will review the order status in PCC under the residents MAR for medications needing to be reordered and reorder if needed. Notify the MD and DON immediately for any resident medications that will not be administered as ordered. The DON and ADON will be in-serviced by the regional nurse on 5/18/23 on pulling the electronic transmission report to show which medications have been reordered and the status of the pharmacy refilling the medication. The medical director was notified of med error and immediate jeopardy as of 5/17/2023. Monitoring The DON / designee will review the med administration audit report 5 days per week to ensure all meds are administered as ordered. Review of the med administration audit report will be a permanent process that will occur indefinitely. This report includes all resident medications. The DON/ADON/Designee will review the electronic transmission report 5 days per week for the status of re-ordered medications. This report shows if there is a new pharmacy order or reorder and the date/time it occurred. This will become a permanent process that will occur indefinitely. The DON/ADON/Designee will audit all resident medications twice per week to ensure a 5-7 day supply of medication are present and maintained. Auditing and monitoring will be a permanent process that will occur indefinitely. This report includes all resident medications. The QA committee will review the findings monthly x 3 months and make changes as needed. Verification of Plan of Removal was as follows: a. Reviewed in-service training initiated on 5/16/2023: the 5 rights of medication administration for all nurses and CMAs. b. Reporting to doctor, DON, and ADON any medication errors for all nurses and CMAs. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Ordering medications for all nurses and CMAs. d. Seizure activity and documentation for all nurses. e. Electronic Transmission Report with inbound and outbound messages, clinical dashboard, integrated pharmacy alerts for DON and ADON. f. Reviewed monitoring tool for medication administration audits. Interviews conducted 5/18/2023 between 2:50 p.m. and 4:15 p.m. revealed LVNs D, E, G, and CMA F had received in-service training and were able to verbalize the 5 rights of medication administration, had knowledge and understanding of when and who needed to be notified in the event of a med error, the process of when and how to reorder medications, and who was responsible to do so. The DON was knowledgeable of the Electronic Transmission Report with inbound and outbound messages, clinical dashboard, integrated pharmacy alerts that she and the ADON would be responsible for. On 5/18/2023 at 4:20 p.m., the Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.