

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2024
NAME OF PROVIDER OR SUPPLIER Brookhaven Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1855 Cheyenne Carrollton, TX 75010	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35152</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for contaminated sharps disposal bins, attached to one (300 Hall MA Medication Cart) of one 300 Hall MA Medication Cart and one (300 Hall Nurse Medication Cart) of one 300 Hall Nurse Medication Cart reviewed for hazards.</p> <p>MA B failed to ensure contaminated sharps in the sharps bin attached to the 300 Hall MA Medication Cart, were below the full line.</p> <p>MA B failed to ensure medications found on the sharps bin insert lid on the 300 Hall MA Medication Cart, were disposed of properly.</p> <p>RN C failed to ensure contaminated sharps in the sharps bin attached to the 300 Hall Nurse Medication Cart, were below the full line.</p> <p>These failures placed residents at risk of being exposed to contaminated sharps, possible bloodborne pathogens, and access to unprescribed medications.</p> <p>Findings included:</p> <p>An observation on 01/30/2024 at 10:07 AM, revealed the plastic insert contained inside the sharps bin attached to MA B's 300 Hall MA Medication Cart was past the full line. Sharps (needles, blades [such as scalpels] and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or pricking the skin) in the insert blocked the insert's lid from closing completely. Eight pills were observed, stuck between the plastic insert and the insert's lid which contributed to the lid from closing properly.</p> <p>In an interview on 01/30/2024 at 10:08 AM, MA B stated she was not aware the sharps in the bin were past the full line because she did not use it. She said the lid on the sharps bin insert should be free to close to ensure staff and resident safety. She said she did not see the medications on the lid of the sharps insert but could see they were preventing the lid from closing completely. She said all staff were responsible to ensure the sharps bin inserts were not filled past the full line however only the nurses had keys to the sharps bins attached to the carts. She said medications should not be disposed of in the sharps bin. She said the full bin and medications posed a hazard for residents and staff.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 01/30/2024 at 10:20 AM, ADON A said the sharps bins should never be filled past the fill line to prevent possible injury to staff or residents. When asked about the medications stuck on the lid of the sharps bin insert, he said medications should not be disposed of in the sharps bin and did not know why the medications were on the sharps bin lid. He stated the medications appeared to be blocking the lid from closing properly. He stated the nurses had keys to the bins and were responsible to ensure the bins were not filled past the full line. He said the medications could be accessible to residents and posed a potential hazard as residents. He said he would find the keys to MA B's cart and change the sharps bin and remove the medications from the lid.</p> <p>An observation on 01/30/2024 at 10:30 AM, revealed the plastic insert in the sharps bin, attached to RN C's 300 Hall Nurse Medication Cart to be past the full line. She said it should not be past the full line because the lid would not close properly which posed a potential hazard. She said the nurses had keys to the sharps bins and should ensure the inserts were not filled past the full line.</p> <p>In an interview on 01/30/2024 at 1:50 PM, the Administrator said the sharps bin inserts should never be filled past the full line because it posed a potential risk of harm to staff and residents. She said they could be stuck by a needle if the lid did not close properly. She said she expected nursing staff to ensure this was done and nursing management to monitor it. She said medications should not be disposed of in the sharps bins and should not be on the lid of the bins where residents could have access to them. She said many of the residents in the facility tend to wander and could have consumed the medications.</p> <p>In an interview on 01/30/2024 at 3:31 PM, the DON said the sharps bins should never be filled past the full line. He said the lid does not close properly when sharps are above the full line which could cause a risk of staff or residents getting stuck with a needle. He said a staff member was recently stuck in this manner and in servicing was conducted. He said medications should be disposed of properly and not placed in the sharps bin. He said he changed out MA B's sharps insert and disposed of the pills that were on the lid. He said he did not feel the medications were accessible because they were in a groove at the back of the insert lid. He said none-the-less the medications should not be there and since the insert lid could not close properly, there was a potential hazard to residents if they were able to get the medications. He said staff are trained on how to dispose of medication properly.</p> <p>Record review of the facility's undated policy titled, Safety and Supervision of Residents, reflected, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation - Facility-Oriented Approach to Safety: 1. Our facility-oriented approach to safety addresses risks for groups of residents. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 3. When accident hazards are identified, the QAPI/Safety Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. 5. The QAPI Committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 2 (Resident # 15 and #20) of 3 residents reviewed for pharmacy services.</p> <p>MA B failed to administer medications timely as ordered by physician to Resident # 20</p> <p>LVN D failed to administer medications timely as ordered by physician to Resident # 15</p> <p>The deficient practice could place residents at risk of not receiving the therapeutic effects from their medications as intended by the prescribing physician order.</p> <p>The findings included:</p> <p>Record review of Resident #15's face sheet dated 01/30/24 revealed an [AGE] years old female, admitted to the facility on [DATE] with diagnoses that included hypertension (blood pressure that is higher than normal), hypothyroidism (happens when the thyroid gland doesn't make enough thyroid hormone) and malignant neoplasm of unspecified site of right female breast (breast cancer)</p> <p>Record review of Resident #15's physician order summary dated 01/30/24 reflected metoprolol succinate ER oral tablet extended release 24-hour 25 mg (metoprolol succinate) give 50 mg via g-tube two times a day for hypertension.</p> <p>Record review of Resident #15's medication administration record dated 01/30/24 reflected Metoprolol ER 50 mg 1 tablet scheduled at 9 am.</p> <p>Observation on 01/30/24 at 11:25 a.m., revealed LVN D administered Resident #15the following medications: Ferrous sulfate 5 cc, Magnesium 400 mg 1 tablet, Potassium chloride 15 cc, Vitamin B-12 1000 mcg 1 tablet and Metoprolol ER 50 mg 1 tablet</p> <p>Record review of Resident #20's face sheet dated 01/30/24 revealed a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses that included insomnia, constipation, gastro-esophageal reflux disease without esophagitis, angina pectoris, vitamin d deficiency, major depressive disorder, Parkinson's disease, and type 1 diabetes mellitus.</p> <p>Record review of resident's #20's physician orders summary dated 01/30/24 reflected, Keppra tablet 500 mg (levetiracetam) give 1 tablet by mouth two times a day for seizures, methocarbamol oral tablet 750 mg (methocarbamol) give 1 tablet by mouth three times a day for muscle spasms and pain, Norco oral tablet 7.5-325 mg (hydrocodone-acetaminophen) give 1 tablet by mouth two times a day for pain, Topamax oral tablet 25 mg (topiramate) give 1 tablet by mouth two times a day for migraines, trospium chloride tablet 20 mg give 1 tablet by mouth two times a day for incontinence/frequency/urgency,</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #20's medication administration record dated 01/30/24 reflected Hydrocodone 7.5 - 325 mg 1 tablet was scheduled at 9 am and 9 pm, methocarbamol 750 mg 1 tablet scheduled at 9am, 2 pm and 9 am, Topiramate 25 mg 1 tablet scheduled at 9 am and 9 pm, levetiracetam 500 mg 1 tablet scheduled at 9 am and 9 pm, tiroprium chloride 20 mg 1 tablet scheduled at 9 am and 9 pm.</p> <p>Observation on 01/30/24 at 11:54 a.m., revealed MA B administered the following medications to Resident #20, Hydrocodone 7.5 - 325 mg 1 tablet, methocarbamol 750 mg 1 tablet, Topiramate 25 mg 1 tablet, levetiracetam 500 mg 1 tablet, tiroprium chloride 20 mg 1 tablet,</p> <p>Interview on 01/30/24 at 11:58 a.m., MA B revealed she still had about three more resident to administer medications that were scheduled to be administered in the morning. MA B stated she was late to administer medications because she was assigned more resident because another medication aide called off. MA B stated she was supposed to administer the medications per orders and within the one-hour window which was one hour before and one hour after the scheduled time. MA B stated medications were supposed to be administered timely because other medications that were scheduled more than once a day could be administered too close to each to other which could have a negative effect on the resident.</p> <p>Interview with LVN D on 01/30/24 at 1:40 p.m., revealed she was a charge nurse and she mainly worked on the night shift, and she had been requested to assist on the 6-2 shift. She acknowledged administering medication to Resident # 15 late. LVN D stated the resident's assignment had changed after one of the staff members called off. LVN D stated the resident's medications was to be administered timely within the one-hour window to prevent any negative effects if the medications were scheduled more than one time per day which could be administered to close to each other.</p> <p>Interview with the DON on 01/30/24 at 3:50 p.m., he stated the charge nurse and medication aide were to administer medication per the orders and per the scheduled time. The DON stated the staff were late because one of the medication aide had called off leaving one medication aide to administer the medications. The DON stated the medications were not supposed to be administered late because some of the medications that were scheduled more than once a day could be administered too close to each other which could lead to a negative effect and at times not being effective if they were pain medications. The DON stated the staff had been in-serviced on medication administration.</p> <p>Record review of the facility policy undated titled Administering oral medications, Purpose. The purpose of this procedure is to provide guidelines for the safe administartions of oral medications. The policy did fcnot indicate the times the mediactions were to be administered.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>35152</p> <p>Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access for one (300 Hall MA Medication Cart) of six of six medication carts reviewed for medication storage.</p> <p>MA B failed to ensure medications found on the sharps bin insert lid on the 300 Hall MA Medication Cart, were disposed of properly.</p> <p>This failure placed residents at risk for unauthorized access to the medication cart and a harmful medication can be consumed placing residents at risk for administration of harmful medication.</p> <p>Findings included:</p> <p>An observation on 01/30/2024 at 10:07 AM revealed, MA B's 300 Hall MA Medication Cart, had eight pills stuck between the plastic insert of the sharps (needles, blades [such as scalpels] and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or pricking the skin) container and the lid, which prevented the lid from closing properly. Residents were observed self-ambulating through the hall in thier wheelchairs.</p> <p>In an interview on 01/30/2024 at 10:08 AM, MA B stated she did not see the medications on the lid of the sharps insert but could see they were preventing the lid from closing completely. She denied that she disposed of the medication but could not say who may have. She said all staff were responsible to ensure medications were secured and disposed of properly. She said medications should not be disposed of in the sharps bin. She said the medications posed a hazard for residents as they could have access to medications not prescribed to them.</p> <p>In an interview on 01/30/2024 at 10:20 AM, ADON A said the medications stuck on the lid of the sharps bin insert should not be disposed of in the sharps bin and did not know why the medications were on the sharps bin lid. He stated the medications appeared to be blocking the lid from closing properly. He said the medications could be accessible to residents and posed a potential hazard as residents. He said he would find the keys to MA B's cart and remove the medications from the lid.</p> <p>In an interview on 01/30/2024 at 1:50 PM, the Administrator said medications should not be disposed of in the sharps bins and should not be on the lid of the bins where residents could have access to them. She said many of the residents in the facility tend to wander and could have consumed the medications. She said she expected the nursing management to monito this and ensure staff were trained on facility policy.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/30/2024 at 3:31 PM, the DON said medications should be disposed of properly and not placed in the sharps bin. He said he changed out MA B's sharps insert and disposed of the pills that were on the lid. He said he was not able to identify what the pills were. He said he did not feel the medications were accessible because they were in a groove at the back of the insert lid, however, the medications should not be there and since the insert lid could not close properly, there was a potential risk to residents consuming the medications if they were able to get the medications. He said staff are trained on how to dispose of medication properly but did not recall when the last training was.</p> <p>Record review of the facility's undated policy, titled, Storage of Medications, reflected, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. 2. Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 6. Hazardous drugs shall be clearly marked as such and shall be stored separately from other medications. 7. Compartments containing drugs and biologicals are locked when not in use. 8. Unlocked medication carts are not left unattended</p>		