

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 38511</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 3 residents (Resident #1 and Resident #2) reviewed for pharmacy services.</p> <p>The facility failed to ensure antibiotics dispensed for Resident #1 and Resident #2 were administered by the staff member who dispensed the medication.</p> <p>This failure could place residents at risk of medication errors.</p> <p>The findings included:</p> <p>1a. Record review of Resident #1's face sheet dated 9/12/2024 revealed an admitted [DATE] and a readmitted [DATE] with diagnoses which included: calculus of kidney (kidney stone).</p> <p>Record review of Resident #1's Care Plan last revised on 8/01/2024 revealed the resident had sepsis/osteomyelitis of vertebra lumbar region (lower spine) with interventions which included administer antibiotic as per MD orders.</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMs score of 15 which revealed the resident was cognitively intact.</p> <p>Record review of Resident #1's physician orders revealed an order with a start date of 8/29/2024 and no end date; give doxycycline mono 100 mg cap, give one capsule by mouth two times a day to prevent infections.</p> <p>Record review of Resident #1's September MAR revealed doxycycline mono 100 mg capsule was scheduled to be administered at 8:00 am and 8:00 p.m</p> <p>Record review of Resident #1's Medication Administration Audit Report dated 9/12/2024 revealed doxycycline mono was documented as administered on 9/12/2024 at 10:25 p.m. by LVN B.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1b. Record review of Resident #2's face sheet dated 9/12/2024 revealed an admitted [DATE] and a readmitted [DATE] with diagnoses which included: multiple sclerosis (chronic autoimmune disease that affections the central nervous system, neuromuscular dysfunction of bladder (brain or nerves that are unable to communicate with the bladder), and hydronephrosis with renal and urethral calculus obstruction (kidney stone that blocked/obstructed the urinary tract system and caused urine to back up in the kidneys).</p> <p>Record review of Resident #2's Care Plan last updated 7/02/2024 revealed the resident had chronic kidney disease with interventions which included provide medications as ordered.</p> <p>Record review of Resident #2's MDS assessment dated [DATE] revealed a BIMs of 15 which indicated the resident was cognitively intact.</p> <p>Record review of Resident #2's physician orders revealed an order with a start date of 9/10/2024 for sulfamethoxazole-trimethoprim tablet 800/160 mg; give 1 tablet by mouth every 12 hours for bacterial infection/UTI for 7 days.</p> <p>Record review of Resident #2's September MAR revealed sulfamethoxazole-trimethoprim tablet 800/160 mg was scheduled to be administered at 9:00 am and 9:00 p.m</p> <p>Record review of Resident #2's Medication Administration Audit Report dated 9/12/2024 revealed sulfamethoxazole-trimethoprim tablet 800/160 mg was documented as administered on 10:40 a.m. by LVN B.</p> <p>During an interview on 9/12/2024 at 9:55 a.m., Resident #2 stated she was being treated for a urinary tract infection. She stated she had a catheter for a long time and was susceptible to UTI's. She stated the doctors had told her as long as she had the catheter, that was something that would happen. She stated she was receiving antibiotics for the infection and was feeling better.</p> <p>During an observation on 9/12/2024 at 10:15 a.m. of MA A medication cart revealed two medication cups that were unlabeled in the top drawer of the cart. Each medication cup had one pill in each cup. One pill was an army green colored capsule stamped 707 (identified as doxycycline monohydrate 100 mg capsule). The second pill was a large white oval shaped pill with a center score mark that was stamped H49 (identified as sulfamethoxazole/trimethoprim 800/160 mg).</p> <p>During an interview on 9/12/2024 at 10:23 a.m., MA A stated the two unlabeled pills were antibiotics that both belonged to Resident #1. MA A stated she was unsure what the antibiotics were but thought maybe cipro and nitrofurantoin but could not be certain. She stated LVN B gave them to her at 8:00 am to give to Resident #1 when she passed the rest of Resident #1's medications. MA A stated she did not give the antibiotics to Resident #1 as instructed by LVN B because she had already administered the rest of Resident #1's morning medications. MA A stated she was trained to only administer medications that she dispensed. She stated Resident #1 wanted all his medications at one time, so she agreed with the nurse to give the antibiotics to him with the rest of the medications. MA A stated antibiotics were a medication that was not available in the medication aide cart and were not administered by the medication aide.</p> <p>During an observation on 9/12/2024 at 10:31 a.m., MA A approached LVN B while surveyor waiting to speak to LVN B and whispered in her ear.</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 - Few</p>	<p>During an interview on 9/12/2024 at 10:31 a.m., LVN B stated she gave only one pill which was clindamycin to MA A to give to Resident #1. LVN B stated Resident #1 liked his medication all at one time. LVN B stated she was trained to use the 5 rights of medication administration but did not explain the 5 rights. She stated she was trained to administer the medications she had dispensed. LVN B stated when she asked MA A to give the antibiotic, she had dispensed MA A had agreed. She stated it was the only time it had occurred.</p> <p>During an observation/interview on 10:34 a.m. of LVN B's medication cart, LVN B removed a blister packet of antibiotics that were bright blue in color (for an unknown resident) and stated that was the medication she gave to MA A to administer. LVN B quickly removed the blister pack when this surveyor stated the pill was colored army green. LVN B revealed a bottle of antibiotics for Resident #1 labeled doxycycline mono 100 mg cap with directions to give 1 capsule by mouth two times a day for prophylaxis (prevention). When asked about the white pill that was also observed in MA A medication cart, LVN B stated she also gave MA A Resident #2's antibiotic for the medication aide to administer. The blister pack for Resident #2's antibiotics were visualized for sulfamethoxazole/TMP DS (Sulfamethoxazole and trimethoprim combination drug) with directions to administer 1 tablet by mouth every 12 hours for 7 days. 4 pills of 14 were dispensed which matched the number of doses that should have been given to Resident #2. LVN B stated she was not aware the antibiotics had not been administered by MA A.</p> <p>During an interview on 9/12/2024 at 11:36 a.m., Resident #1 stated he received medication by only one person and stated that person was the one in the hallway passing meds (indicating MA A). He stated he gets a cup full of meds and remembered a purple capsule but could did not know if they were his antibiotics. He stated no other person had approached him to give medications.</p> <p>During an interview on 9/12/2024 at 11:39 a.m., Resident #2 stated she had not gotten any of her meds today that she could remember. After thinking about it for a few minutes she stated at approximately 6:00 am she was given her synthroid (medication to treat hypothyroidism). She stated her antibiotic was a big white pill. She stated she thought maybe someone came to give it to her in the middle of the night at approximately 5:00 am but could not remember the person who gave it to her the medications.</p> <p>During an interview on 9/12/2024 at 5:28 p.m., the DON stated her expectation for medication administration was the person who pops (dispenses) the medication should administer the medications. The DON stated the LVN should not pop meds and give them to the MA to administer. The DON stated this was important because the facility had to ensure the 5 rights of medication administration which included the right medication in the right dose to the right patient. She stated the facility policy was for medication to be dispensed 1 hour before to 1 hour after the scheduled time. She stated if staff was not able to administer medications during the time frame they should notify the physician to ensure it was okay to give at a later time.</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 - Few</p>	<p>Record review of a facility policy, titled Administering Medications last revised April 2019 revealed: Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame 5. Medication administration times are determined by resident need and benefit, not staff convenience. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified. 10. The individual administering the medication checks the label THRR (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p>		