STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455532	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 46892 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 and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 2 of 2 residents (Resident #1 and Resident #2) reviewed for pharmacy services. The facility failed to ensure Resident #2's family member signed the medication release form for medications which included Ativan (also known as Lorazepam, a controlled medication used for anxiety) on 02/09/2024 and 02/16/2024. The facility failed to ensure Resident #2's Ativan was accurately reconciliated when she returned to the facility on [DATE], 02/18/2024, and 12/15/2024. The facility failed to ensure MA B administered Resident # 1's Eliquis during medication administration on 01/27/2025. These failures could place the residents at risk of not having medications available for use, drug diversion, medications errors, and inaccurate records. Findings included: 1. Record review of a face sheet dated 01/27/2025 indicated Resident #2 was a [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included senile degeneration of the brain (a condition characterized by cognitive decline, memory loss, and difficulty with learning and problem-solving), parkinsonism (movement disorder of the nervous system), and generalized anxiety disorder. Record review of the Quarterly MDS assessment dated [DATE], indicated Resident #2 was able to make herself understood and understood others. The MDS assessment indicated Resident #2 had a BIMS summary score of 9, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #2 was independent for all ADLs. The MDS assessment indicated Resident #2 received antianxiety medication in the past 7 days. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455532	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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 - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Order Summary Report indicated she had an order for Ativan (also known as Lorazepam a controlled medication used for anxiety) 0.5 mg give 1 tablet by mouth three times a day for anxiety with a start date of 01/15/2023. Record review of Resident #2's care plan last reviewed on 01/14/2025 indicated she used antianxiety medications related to an anxiety disorder. Interventions included to give antianxiety medications ordered by the physician. Record review of Resident #2's Release of Responsibility for Medication, which included Ativan, indicated: Leaving: 02/09/2024 at 12:00 PM, signed by RN D, the signature for the Resident/Family/Legal Representative was missing. Returned: 02/11/2024 at 2:25 PM, signed by LVN C, the signature for the Resident/Family/Legal Representative was missing. Record review of Resident #2's Release of Responsibility for Medication, which included Ativan, indicated: Leaving: 02/16/2024 at 12:00 PM, signed by RN D, the signature for the Resident/Family/Legal Representative was missing. Returned: 02/18/2024 at 3:30 PM, signed by LVN A, the signature for the Resident/Family/Legal Representative was missing. Record review of Resident #2's Medication Release/Receipt, which included Ativan, indicated: Leave of Absence from 12/13/2024-12/15/2024, signed by Resident #2's Resident Representative and dated 12/13 (no year indicated). There was no signature for person completing the form. The total number of pills returned was blank, not completed. Date/Time returned was blank, not completed. Record review of Resident #2's Individual Patient's Narcotic Record indicated a pharmacy label with directions for Lorazepam 0.5 mg give 1 tablet by mouth three times a day, dated 01/09/2024 indicated: 02/09 (no year) at 07:00 AM with amount remaining 3, below the entry there was a note resident came back with none on this card dated 02/11/2024 signed by MA F, the other staff members signature was illegible. Record review of Resident #2's Individual Control Drug Record indicated a pharmacy label with directions for Lorazepam 0.5 mg give 1 tablet by mouth three times a day, dated 02/08/2024 indicated: an undated entry with a note resident back from out on pass with 23, no staff signatures. Next entry dated 2/12 (no year) 7:00 AM, amount given 1, remaining balance 22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455532	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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 - Minimal harm or potential for actual harm Residents Affected - Some	This indicated between 02/09-02/11 10 tablets of Resident #2's Lorazepam were used. According to the directions for the Lorazepam only 8 tablets should have been used. Record review of Resident #2's Individual Control Drug Record indicated a pharmacy label with directions for Lorazepam 0.5 mg give 1 tablet by mouth three times a day, dated 02/08/2024 indicated: An entry on 02/16 (no year) at 7:00 AM, amount given 1, remaining balance 11. Next entry indicated came back with 1, signed by MA F with no date. Next entry dated 02/18 (no year) at 7:00 PM, amount given 1, balance remaining 0. This indicated between 02/16-02/18 10 tablets of Resident #2's Lorazepam were used. According to the directions for the Lorazepam only 7 tablets should have been used. Record review of Resident #2's Individual Control Drug Record indicated a pharmacy label with directions for Lorazepam 0.5 mg give 1 tablet by mouth three times a day, dated 12/10/2024 indicated: 12/13 (no year) at 1:00 PM, 1 tablet was administered, the balance was 22 and there was a note signed by LVN C to indicate sent with resident. 12/15 (no year) at 7:00 PM, 1 was given, balance indicated 21 then scratched off and balance of 13 noted with resident returned signed by MA E. There was no note prior to MA E's 7:00 PM entry to indicate how many Lorazepam tablets Resident #2 returned with. This indicated between 12/13-12/15, 9 tablets of Resident #2's Lorazepam were used. According to the directions for the Lorazepam only 6 tablets should have been used. During an interview on 01/27/2025 at 8:49 AM, MA E said there was a form filled out by the nurse when the residents went out on pass with their medications. MA E said if they noticed medications were missing when the resident returned it should be reported to the DON. During an interview on 01/27/2025 at 9:37 AM, Resident #2 said when she went out on pass, she did not have to take any extra doses of Ativan, but sometimes when she was attempting to administer it to herself, she might drop one down the sink. During an interview on 01/27/2025 at 11:03 AM, MA F said when residents went out on pass with their medications, they wrote down how many the resident left the facility with and when the resident returned, they wrote down how many the residents returned with. MA F said if there was a discrepancy noticed with the amount of the medications returned, she would report it to the nurse. MA F said when she started her shift usually Resident #2's medication was already on the medication cart. MA F said she had not noticed any discrepancies with Resident #2's Ativan. MA F said it was important to ensure the count was correct with controlled medications to ensure the resident was not abusing the drug and to ensure none were missing and nobody had taken any of the medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455532	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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 - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/27/2025 at 12:21 PM, MA E said she had noticed a couple months ago, maybe 2-4 months ago, that Resident #2's count on Ativan was not correct because she had called the pharmacy to check on a refill and the pharmacy had informed her it was too soon to fill it. MA E said she notified LVN C, and LVN C said she would take care of it. During an interview on 01/27/2025 at 12:24 PM, LVN C said when Resident #2 went out on pass the medication release form was completed, signed by Resident #2's family member that he was responsible for her taking the medications, and she signed the form as well. LVN C said usually, the charge nurse was responsible for completing the medication release form. LVN C said she always made sure she completed the form. LVN C said the narcotic book was also signed to indicate the resident was out on pass. LVN C said usually, the medication aide signed the narcotic book. LVN C said she would not say she noticed Ativan was missing, but one weekend she noticed Resident #2 had taken more Ativan than she was supposed to. LVN C said Resident #2 told her she might have dropped one. LVN C said she notified the NP but did not notify anyone else. LVN C said nobody had reported to her that there was a discrepancy in Resident #2's Ativan. LVN C said it was important to ensure the count for the Ativan was correct because it could be the employee or resident taking the medication, and they did not want the resident to over sedate themselves. During an interview on 01/27/2025 at 12:53 PM, Resident #2's family member said when she went home Resident #2 administered her own medications with his assistance. Resident #2's family member said Resident #2 may have dropped a pill, but he was not sure of that. Resident #2's family member said if anything she did not take all her medications and missed some doses while at home. Resident #2's family member said he had not been contacted by the facility or been notified that there were more pills of the Ativan used or to ask if she had been taking too much Ativan while out on pass. During an interview on 01/27/2025 at 1:52 PM, the Administrator said she had not been notified of any discrepancies with Resident #2's Ativan. The Administrator said the staff would not be required to report to her if 1-3 tabs of the Ativan were missing when Resident #2 returned to the facility. The Administrator said they could not dictate what the family did with the medications once they were released to them. During an interview on 01/27/2025 at 2:28 PM, the DON said when the residents went out on pass the medications were counted and they ensured the responsible party knew how to administer the medications, and a form was filled out when the resident left and when the resident returned. The DON said if discrepancies with the medications were noted the staff should notify her. The DON said she had not been notified of any discrepancies with Resident #2's Ativan. The DON said she was unable to find Resident #2's Medication Release Form from 12/13/2024-12/15/2024. The DON said the copy she provided was given to them by Resident #2's family member because they took pictures of all the forms when they took Resident #2 home. The DON said she did not know what happened to the form. The DON said it was important for the counts to be accurate with the narcotics because they were supposed to keep up with it, there was a risk of overdose, or the nurse herself could be taking it. During an interview on 01/27/2025 at 3:51 PM, the Administrator said she expected for the staff to educate the family on the residents' medications when they went out on pass with them. The Administrator said she expected the staff to complete the medication release form and have the representative sign when they took the medications. The Administrator said it was important for the medication release form to be completed correctly so they had the correct count in house, and they could check over the medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455532	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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 - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/27/2025 at 4:04 PM, RN D said she was no longer employed at the facility. RN D said when Resident #2 went out on pass she would sign out the medications with the count on them and have the family member sign, and when she returned the family member was supposed to sign and the medications were counted again. RN D said she did not remember what happened because she always had the family sign the sheet. RN D said she never noticed a discrepancy in Resident #2's Ativan count. RN D said it was important to count the medications when the resident left and came back and ensure the count was correct to prevent misappropriation of narcotics. 2. Record review of a face sheet dated 01/27/2025 indicated Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included paroxysmal atrial fibrillation (irregular heart rhythm). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated she was able to understand others and was understood by others. The MDS assessment indicated Resident #1 had a BIMS score of 6, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #1 was independent with eating, oral, toileting, and personal hygiene, and required set-up assistance with showering/bathing herself. The MDS assessment indicated Resident #1 had an anticoagulant during the last 7 days. Record review of Resident #1's care plan last reviewed 12/03/2024 indicated she was on anticoagulant therapy. Resident #1's interventions included for the resident/family/caregiver teaching to include take/give the medication at the same time each day. Record review of Resident #1's Order Summary Report dated 01/27/2025 indicated Eliquis 5 mg give 1 tablet by mouth two times a day for anticoagulant (blood thinner) with a start date of 09/10/2024. Record review of Resident #1's January 2025 MAR indicated Eliquis 5 mg was administered by MA B on 01/27/2025 for the AM dose (precise time not indicated). During an observation of medication administration on 01/27/2025 starting at 7:56 AM, MA B did not administer Resident #1's Eliquis 5 mg. During an interview on 01/27/2025 at 8:59 AM, MA B said she had not administered Resident #1's Eliquis 5 mg. MA B said Resident #1 did not have any Eliquis. MA B said the pharmacy had not been sending Resident #1's Eliquis in a timely manner before the Eliquis ran out. MA B said she had notified the DON and Administrator that the pharmacy had not been sending refills out prior to the current supply running out. MA B said she had not heard back from them regarding the situation. MA B said Resident #1's last tablet of Eliquis was administered yesterday (01/26/2025), and that the Eliquis should arrive later today (01/27/2024). MA B said the Eliquis was available in the facility's emergency medication supply, and she would have the nurse administer it. MA B said, she had not administered the medication because it was her fault, she was rushing, and was not paying attention. MA B said it was important for the residents to receive their medications so they would not have any type of problems and to make sure the residents were on the right track. MA B said Resident #1 needed the Eliquis for her heart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455532	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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 - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/27/2025 at 2:28 PM, the DON said MA B should have gone through Resident #1's MAR pill by pill while administering her medications. The DON said MA B should not have signed off Resident #1's Eliquis as administered if she did not administer it. The DON said MA B should have realized Resident #1 did not have any Eliquis, stopped administering medications, and notified her to get it from the facility's emergency medications. The DON said she had not been notified by the staff of any issues refilling residents' medications from the pharmacy. The DON said it was important for the residents to receive their medications as ordered to treat their disease processes. During an interview on 01/27/2025 at 3:44 PM, the Administrator said she expected for the staff to give medications as ordered on the MAR and administer them correctly. The Administrator said the DON was responsible for overseeing that this was done. The Administrator said not administering medications as ordered went against the doctor's orders, and they would not be giving the level of care they should to the resident. Record review of the facility's policy titled, Nursing Facility Medication Administration, from the Pharmacy Policy & Procedure Manual 2003, indicated, .2. Facility staff administering medication shall comply with the following .b. Medications shall be administered unless the resident refuses or exhibits symptoms that contraindicate medication administration. c. If a medication is not administered, the staff member shall document in the resident's record why the medication was not administered . Record review of the facility's policy titled, Leave of Absence with Medications, from the Pharmacy Policy & Procedure Manual 2003, indicated, .Current medication orders and directions for use are reviewed with the resident or responsible party before the resident leaves the facility . 4. The entire medication container with Rx labels is to be taken on pass, the resident or responsible party must sign out for it on a record of medication release . The policy did not address reconciliation of the medications when the resident returned to the facility.