STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455675	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Amarillo Rehabilitation and Nursing Ce	5601 Plum Creek Dr Amarillo, TX 79124

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 - 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** 48161 Based on observation, interview and record review, the facility failed to establish a system of record of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained periodically reconciled for 1 of 18 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1's OxyContin Oral Tablet ER 12-hour abuse-deterrent 10mg-28 count was accounted for at the time of receiving from the facility's Pharmacy on 05/02/2025. This failure could place residents at risk of not receiving medication therapy that would be effective for their treatment, resulting in the exacerbation of conditions and disease processes. Findings included: Record review of Resident #1's Admission record dated 05/21/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Cauda equina syndrome(compression of the nerve roots at the lower end of spinal cord), chronic pain syndrome, displaced fracture of the left tibial and benign prostatic hyperplasia(enlarged prostate). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1's BIMS score was a 15 out of 15 indicating his cognition was intact. In section J0100 it was documented that Resident #1 received scheduled and Prn pain medication. Record review of Resident #1's care plan dated 05/12/2025 revealed the following: Focus: The resident has opioid pain medication ordered r/t chronic pain with interventions of administer medication as ordered. Record review of Resident #1's active physician orders revealed the following: Orders dated 04/18/2024 OxyContin Oral Tablet ER 12-hour abuse-deterrent 10mg. Give one tablet by mouth every 12 hours for pain. Record review of Medication paper from Pharmacy dated 5/2/25 revealed the following: (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patient: Resident #1 Drug Name: Oxycontin Tab 10mg ER Qty filled: 28 Days' supply: 14 Filled date: 5/2/25 Received by: LVN A's signature Driver: Pharmacy Driver's signature Record review of Resident #1's Medication Administration Record dated May 1-21 2025 revealed Resident #1 received pain medication daily. In an interview/observation on 5/21/2025 at 11:22 AM, Resident #1 was lying in his bed, his head slightly raised. Resident #1 stated he had not missed any of his pain medication and had not experienced any distress. In an interview on 05/21/2025 at 11: 40 AM, the ADM stated that she was unsure if Resident #1's medication was received the evening of 5/2/2025 because it was not accurately received by LVN A or accurately dropped off by pharmacy driver. The ADM stated this failure could cause a resident to need his medication and not have it. The ADM stated she was responsible to ensure her staff was aware of accurately receiving medications and was unsure if the medication ever arrived at the facility due to the inproper count of the receipt of medications the night of 5/2/25. In an interview on 5/21/2025 at 6:20 PM, LVN A stated she was the nurse responsible for signing for the OxyContin Oral Tablet ER 12-hour abuse-deterrent 10mg delivered by the Pharmacy. LVN A stated the night on 5/2/2025 the pharmacy driver dropped of the crate with the medications and when she had time she would count the medications against the pharmacy list. LVN A stated the pharmacy driver would come back and pick up the empty crate along with the signed medication check list. LVN A stated the night on 5/2/2025 she and LVN B were the two nurses on duty, she stated they were busy and is unsure what happened. LVN A stated after she would check the medications in, she would put them a plastic bag and she and LVN B would distribute the medications to the unit the resident lived on. LVN A stated she was unsure if the medication was in the bag and is unsure if the medication was even delivered. LVN A stated LVN B was the one responsible for the medications for Resident #1's unit. LVN A stated she did not have LVN B sign any paper that he received the OxyContin Oral Tablet ER 12-hour abuse-deterrent 10mg for Resident #1. LVN A stated a possible negative outcome for not ensuring the medications were distributed accurately would be a resident could go without their medication. LVN A stated she was responsible for this incident because her signature was on the pharmacy checklist as she received it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 05/21/2025 at 10:45 PM, LVN A was sitting at the nurses station and the pharmacy driver was standing outside the nurses station observing LVN A count the medications in, she was checking the medication and putting a checkmark next to the medication and the resident's name accounting for that medication. During the counting of the medication, an observation was made of four medications that were on the list but not present and LVN A circled the medication name and wrote missing next to the medication, she had the pharmacy driver initial next to the medication and her note that the medication was missing. In an interview on 05/21/2025 at 11;15 PM, the Pharmacy driver stated that prior to the incident on 5/2/25 he would drop of the crate with the medication to the nurse on duty and would leave the facility and do his other rounds and then on his way back through town he would pick up the empty crate with the list of medication sheet that was signed off by the nurse. The Pharmacy driver stated he did not watch the nurse count in of medications prior to the 05/02/2025. In an interview on 05/22/2025 at 12:15 AM, LVN B stated he had not worked at the facility for very long on the night on 5/2/2025 and stated he did not remember seeing Resident #1's Oxycontin ER and doesn't remember checking it in. LVN B stated he did not sign for any medications(narcotics) given to him by LVN A on 5/2/2025. LVN B stated a possible negative outcome for not having the medication accurately counted in by the pharmacy and having missed medication would be a resident could need his medication and not have it causing the resident to be in pain or distress. In an interview on 05/22/2025 at 11:45 AM, the ADON stated it was the administrative personnel (new DON will not start until later this month) who were responsible to ensure accuracy of receiving medication and their staff were aware of such processes. The ADON stated she was unsure if the medication arrived at the facility due to the inaccurate process of counting in the medication for Resident #1. The ADON stated that a possible negative outcome for not properly processing the medication when it arrived at the facility would be a resident would not have their medication and possible be hospitalized . Record review of Controlled Medication-Ordering and receipt, not dated reflected the following: Medication included in the Drug Enforcement Administration classification as controlled substances, and medications classified as controlled substance by state law or subject to special ordering, receipt, and recording requirements in the facility, in accordance with federal and state laws and regulations. Procedure: A controlled medication accountability record is prepared when receiving or checking in a controlled substance medication for a resident .