

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Monument Hill Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 State Loop 92 LA Grange, TX 78945	
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** Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; for all medication carts reviewed for controlled drug reconciliation. The facility failed to ensure they stored and labeled 34 tablets of 5-325 Norco for Resident #1 13 tablets of 5-325 for Resident #2 and 2 tablets of Oxycodone 5mg for Resident #3. This failure could place residents who receive medications at risk of not receiving the intended therapeutic effects of their prescribed medications. Findings included: Record review of facility self-report dated [DATE] reflected on [DATE] the facility conducted a narcotics count audit for discontinued medication. During the count they identified 2 individual Resident Controlled Substances Record Sheets of discontinued medication that did not have the corresponding medication. One Resident Controlled Substances Record Sheet was for Resident #1 and reflected 34 tablets of Norco 5-325 (a prescription medication combining 5 mg of hydrocodone (a narcotic opioid) and 325 mg of acetaminophen (the active ingredient in Tylenol) were missing and One Resident Controlled Substances Record Sheet for Resident #2 reflected 13 tablets of Norco 5-325 were missing. The facility conducted a full audit of narcotics for all carts in the building and identified a 3rd Resident Controlled Substances Record sheet for Resident #3 for Oxycodone 5mg tablets that reflected a count showed 5 tablets were present, but the medication blister pack contained 3 tablets. Record review of Resident #1, #2, and #3's MAR reflected residents received all prescribed medications. Resident #1 and Resident #3 are deceased. Resident #2 was assessed for pain, and she denied having pain and stated her pain medications are controlling her pain. The facility conducted a search of all medication carts, the drug destruction waste bin and other locations throughout the facility and were unable to locate the missing narcotics. The facility reviewed the pharmacy destruction log, and the medications were not present. After a thorough investigation the facility had been unable to locate the 34 tablets of 5-325 Norco, the 13 tablets of 5-325, and the 2 tablets of Oxycodone 5mg. Record review of Resident #1's Individual Resident's Controlled Substance Record undated reflected a count of 34 tablets of 5-325 Norco with no signatures indicating a count of the narcotics. Record review of Resident #2's Individual Resident's Controlled Substance Record undated reflected a count of 13 tablets of 5-325 Norco with one illegible signature next to the number 13. Record review of Resident #3's Individual Narcotic Record reflected a count of 5 Oxycodone 5mg with the word expired and two illegible signatures. Record review of report by the CP, undated, to the facility reflected, On [DATE] I was notified of a controlled substance count discrepancy at [facility name] in [location]. The outgoing DON did not do a chain of custody med count upon resigning. The controlled substances for destruction were not logged and were kept under 2 locks in the DON office. The incoming (interim) DON did a med count with another employee when she became the sitting DON. (continued on next page)		

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The counts were not accurate according to the log sheets. A report was filed with HHSC and with the local police. An internal investigation was carried out. Discrepant quantities were noted on the drug destruction log. During an interview on [DATE] at 10:53 AM with the Administrator he said the IDON conducted an audit of discontinued medication when the FDON left. The Administrator said the audit was conducted because the FDON had left the day prior and the IDON decided to do an audit. The Administrator said the FDON did not do a narcotics count when she left the facility. The Administrator said when the FDON left, a narcotic count should have been done to make sure the narcotics count was correct before the IDON began working. The Administrator said the Resident Controlled Substances Record Sheets along with the discontinued medication should have gone together in the double lock cabinet located in the facility DON office. During an interview on [DATE] at 12:18 PM with the FDON she said when she was the DON, she was the only person with a key to the discontinued narcotics double locked medication box. She said she did not remember receiving the discontinued pills. The FDON said normally, there were two signatures on the discontinued Resident Controlled Substances Record Sheets, the signature of the nurse or MA who gave her the retired or discontinued medication and her signature. The FDON said she had no idea what happened with any of those pills. She said the pills should have been there and if they were not, she did not know what happened to them. During an interview on [DATE] at 1:00 PM with Resident #2 she said received all her pain medications and she was not in pain. Resident #2 said she did not have any concerns. During an interview on [DATE] at 1:14 PM with the IDON she said she was now a Charge Nurse but was the IDON from [DATE] until [DATE], before the current DON was hired. The IDON said on [DATE] she went into the FDONs office and found it in disarray. She said she began pairing the Resident Controlled Substances Record Sheets with the narcotic medication located in the facility DON lock box. She said she could not locate the narcotics for Resident #1's Controlled Substances Record Sheets that reflected 34 tablets of Norco 5-325 or the narcotics for Resident #2's Controlled Substances Record Sheets that reflected 13 tablets of Norco 5-325 were missing. The IDON said when facility conducted a full audit of narcotics for all carts in the building, they identified a 3rd Resident Controlled Substances Record Sheet for Resident #3 for Oxycodone 5mg tablets that reflected the count showed 5 tablets were present, but the medication blister pack contained 3 tablets. She said she did not think that the FDON took the narcotics because if she was going to take the medication, she would have disposed of the Controlled Substances Record Sheets. The IDON said that the Resident Controlled Substances Record Sheet should be rubberbanded together with the corresponding narcotics that were to be disposed of and there should have been a log listing all the Resident Controlled Substances Record Sheets. The IDON said she could not locate a log of the discontinued narcotics. The IDON said the FDON should have kept a log of the narcotics the FDON collected. The IDON said that both Resident #2 and Resident #3's medications were discontinued because the residents died. The IDON said Residents #1, Resident #2, and Resident #3 received all their prescribed medication as reflected in their MAR. The IDON said that Resident #2's Oxycodone 5mg prescription was changed and the 5mg tablets should have been removed from the cart and given to the FDON and placed in the facility DON lock box for destruction by the consultant pharmacist. The IDON said CMA A told her that she remembered she gave the FDON the discontinued medication for Resident #2, but MA A said that the FDON did not ask her to sign that she gave the medication to her. The IDON said it was not in the facility policy to have two signatures when counting discontinued narcotics to be given to the DON for the pharmacist's disposal. The IDON said in the past, the nurse or MA and the DON would sign the Resident Controlled Substance Record Sheets indicating that the count of the narcotics was correct. There would be two signatures on the Resident Controlled (continued on next page)		

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