

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2024
NAME OF PROVIDER OR SUPPLIER Kirkwood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2590 Loop 337 N New Braunfels, TX 78130	

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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031</p> <p>Based on interview and record review the facility failed to, based on the comprehensive assessment of a resident, ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 6 residents (Resident #1) reviewed for quality of care .</p> <ol style="list-style-type: none"> 1. The facility staff administered Resident #1's digoxin (medication used to manage and treat heart failure and certain abnormal heart rhythms) without documenting the ordered blood pressure and pulse per the physician ordered parameters from [DATE] to [DATE], [DATE] to [DATE], and [DATE] to [DATE] (23 days) and failed to hold the medication as ordered per parameters on [DATE] and [DATE] . 2. The facility staff failed to administer Resident #1's midodrine (medication used to raise abnormally low blood pressure) as ordered to be given PRN every 8 hours for SBP<100 on [DATE], [DATE], [DATE], [DATE], and [DATE] (5 instances) when the resident's SBP was below 100 . 3. The facility staff failed to assess Resident #1 for a change of condition related to continued complaints of nausea on [DATE], [DATE] and [DATE]. Resident #1 was discharged to the hospital by EMS on [DATE] and expired in the emergency room . <p>An immediate jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 8:51 p.m While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because the facilities need to evaluate the effectiveness of their corrective actions.</p> <p>These failures could place residents at risk of a critically low pulse and blood pressures, inadequate blood flow, missed signs and symptoms of illness, hospitalization and death.</p> <p>The findings were:</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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. Closed record review of Resident #1's face sheet, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included osteomyelitis, unspecified (a serious infection of the bone that can be either acute or chronic), unspecified atrial fibrillation (an irregular and often rapid heart rhythm), atherosclerotic heart disease of native coronary artery without angina pectoris (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of the coronary artery without chest pain or discomfort), and acute kidney failure (sudden or rapid failure of the kidneys being unable to filter waste products from the blood). The resident was discharged to the hospital by EMS on [DATE].</p> <p>Closed record review of Resident #1's care plan reflected a focus, initiated on [DATE], for Digoxin therapy related to Heart Failure with an intervention to report to the physician any anorexia, nausea, vomiting, diarrhea, or visual disturbances. Another focus initiated on [DATE] for an indwelling foley catheter with multiple interventions included to monitor, record, and report to the MD no urine output and an increased pulse.</p> <p>Closed record review of Resident #1's admission MDS assessment dated [DATE] indicated the resident had a BIMS ,d+[DATE] indicating the resident had moderate cognitive impairment, had a foley catheter, and used a wheelchair.</p> <p>Closed record review of Resident #1's physician orders reflected an order with a start date of [DATE] for digoxin 0.0625 mg once daily for heart rate, hold for SBP <100 or heart rate < 60. (the medication was scheduled for the administration time of 7:00 a.m.)</p> <p>Closed record review of Resident #1's EMAR for February 2024 reflected Resident #1's digoxin was documented as administered by CMA C on [DATE] to [DATE], [DATE] to [DATE] and [DATE] to [DATE] without documentation of the blood pressure or pulse readings. It was documented as administered by CMA D on [DATE] without documentation of the blood pressure or pulse readings.</p> <p>Closed record review of Resident #1's EMAR for [DATE] reflected Resident #1's digoxin was documented as administered by CMA C on [DATE], [DATE] to [DATE] and [DATE] to [DATE] without documentation of the blood pressure or pulse readings.</p> <p>Closed record review of Resident #1's EHR under the vital signs tab, reflected there were 4 blood pressure and 3 pulse readings from [DATE] to [DATE]. The documentation was as follows: on [DATE] at 8:06 a.m. B/P- ,d+[DATE], P-96. On [DATE] at 1:53 p.m. B/P- ,d+[DATE] with no pulse documented. On [DATE] at 8:18 a.m. B/P- ,d+[DATE], P-88.</p> <p>Closed record review of Resident #1's EHR under the vital signs tab, reflected there were 2 blood pressure and 1 pulse reading for [DATE]. The documentation was on [DATE] at 8:27 p.m. B/P- ,d+[DATE], P- 97. On [DATE] at 3:30 p.m. B/P- ,d+[DATE] with no pulse documented.</p> <p>2. Closed record review of Resident #1's physician orders reflected an order with a start date of [DATE] for midodrine 2.5mg every 8 hours as needed for low BP, give if SBP<100.</p> <p>Closed record review of Resident #1's EMAR for February 2024 reflected midodrine spaces for administration and blood pressure documentation were blank for the entire month of February.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Closed record review of Resident #1's EMAR for [DATE] reflected midodrine spaces for administration and blood pressure documentation were blank for [DATE] to [DATE].</p> <p>Closed record review of Resident #1's EMAR for February 2024 reflected on [DATE] digoxin was held for B/P- ,d+[DATE] and indicated the midodrine should have been administered per ordered parameters.</p> <p>Closed record review of Resident #1's EHR under the vital signs tab, reflected midodrine should have been administered per ordered parameters on [DATE] at 8:06 a.m. B/P- ,d+[DATE], [DATE] at 8:18 a.m. B/P- , d+[DATE], [DATE] at 8:27 p.m. B/P- ,d+[DATE], and [DATE] at 3:30 p.m. B/P- ,d+[DATE].</p> <p>3. Closed record review of Resident #1's physician orders reflected an order with a start date of [DATE] for zofran (anti-nausea medication) 4mg tablet every 6 hours PRN for nausea or vomiting.</p> <p>Closed record review of Resident #1's EMAR for [DATE] reflected the resident was administered zofran 4mg tab on [DATE] at 6:41 a.m. by RN B, on [DATE] at 6:48 p.m. by LVN A and on [DATE] at 8:14 a.m. by RN B.</p> <p>Closed record review of Resident #1's EMAR linked progress notes for Zofran 4mg tab reflected a note, dated [DATE], at 7:36 p.m., indicated the administered dose at 6:41 a.m. was effective with no other documentation or assessment between these two times regarding nausea. A linked note, dated [DATE] at 9:54 p.m., indicated the dose administered at 6:48 p.m. was effective. A linked note, dated [DATE] at 10:00 a.m., indicated the dose administered at 8:14 a.m. was ineffective.</p> <p>Closed record review of Resident #1's progress notes reflected a note, dated [DATE] at 9:59 p.m., indicated the resident complained of pain, muscle spasms, and nausea and he was medicated for pain and nausea and both were effective and the resident was resting comfortably, eyes closed, respirations even and unlabored.</p> <p>Closed record review of Resident #1's Physician orders reflected an order with a start date of [DATE] at 10:15 a.m. for Zofran 8mg tablet every 6 hours PRN for nausea and vomiting.</p> <p>Closed record review of Resident #1's EMAR for [DATE] reflected the resident was administered zofran 8mg tab on [DATE] at 11:01 a.m. by RN B.</p> <p>Closed record review of Resident #1's EMAR linked progress reflected a note for Zofran 8mg tab, dated [DATE] at 12:52 p.m., and indicated the dose administered at 11:01 a.m. was effective.</p> <p>Closed record review of Resident #1's EHR, under assessments, reflected an SBAR communication form, dated [DATE]. The Situation section was not filled out, the resident evaluation was not filled out, B/P- , d+[DATE], P-97, R-20, O2 Sat 98% with no date or time taken.</p> <p>Closed record review of Resident #1's EHR, under assessments, reflected a Nursing Home to Hospital Transfer Form, dated [DATE], with blood pressure and pulse documented as B/P- ,d+[DATE], P- 97 and under reason for transfer Urinary Incontinence was listed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Closed record review of Resident #1's progress notes reflected a change in condition note by an unknown nurse, dated [DATE] at 3:25 p.m., indicated to refer to the change in condition form for the full assessment. The blood pressure in the note was B/P ,d+[DATE], P-97 and the date and time next to it were [DATE] at 8:27 p.m. The pulse in the note had the date and time taken as [DATE] 8:28 p.m. The temperature of 97.1 Fahrenheit and O2 sat of 98% had the date and time of [DATE] at 11:17p.m.</p> <p>Closed record review of Resident #1's progress notes reflected a note by an unknown nurse, dated [DATE] at 1:08 p.m., indicated the foley catheter was not draining and it was replaced. The resident having bladder spasms. Will continue to monitor for output.</p> <p>Closed record review of Resident #1's progress notes reflected a note by an unknown nurse, dated [DATE] at 9:19 p.m., indicated at approximately 2:30 p.m. the foley catheter was not draining, his abdomen was hard, and the resident was having spasms when palpating around the bladder. The resident complained of pain but was unable to focus or tell where pain was .Skin clammy, grayish, and pale. Lethargic and unable to answer questions. The NP was notified and 911 called and the resident left the facility at 1:20 p.m.</p> <p>Closed record review of Resident #1's EMAR for February 2024 reflected Zofran 4mg tablet PRN nausea and vomiting was not administered for the entire month (indicating the nausea was a new change for the resident in March).</p> <p>Closed record review of Resident #1's Physical Therapy encounter notes, dated [DATE] at 1:58 p.m., reflected under response to session was documented .patient in a lot of pain today and has been asking for increased pain meds since last night, nursing had to change catheter and is still not voiding, informed nursing and requesting he be sent to the hospital due to patient not looking good, in that he was ashy, clammy, and out of it.</p> <p>Closed record review of Resident #1's Occupational Therapy encounter notes, dated [DATE] at 2:19 p.m., reflected under response to treatment.Patient tolerated therapy but was not well. Patient was sick at his stomach, clammy and ash color. Patient was drooling while laying on his side with eyes halfway open. Nursing made aware of situation and after further review patient is being sent out.</p> <p>Record review of EMS run report for Resident #1, dated [DATE] at 3:04 p.m., reflected .Upon arrival a nurse greets us and states the patient hasn't produced urine in several days and they are concerned. When EMS arrived at the resident's bedside the resident was Alert and oriented to person, place, time, and situation and was giving EMS his extensive history and complaining of nausea and pain to his sacrum area but denied any chest pain, shortness of breath, headache, blurred vision, dizziness, abdominal pain, or any other pain or injury. The resident was transported without change or incident. Under primary complaint documented nausea and not producing urine and had not eaten in 3 days. Blood pressure and pulse readings were documented at 3:15 p.m. B/P- ,d+[DATE], P-76, and at 3:17 p.m. B/P-,d+[DATE], P-82, at 3:22 p.m. B/P- , d+[DATE], P- 79, at 3:27 p.m. B/P- ,d+[DATE], P-74 and at 3:40 p.m. B/P- ,d+[DATE], P-71.</p> <p>Record review of the facility pharmacy review dated [DATE], by PH indicated a review was completed on [DATE] and [DATE] and included Resident #1. The pharmacy review indicated Medication regimen reviewed. No recommendations.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's emergency room record dated [DATE] reflected arrival vital signs at 4:00 p. m. included B/P- ,d+[DATE], P- 66, in moderate distress, with pale skin and conjunctiva. The resident was moved to the resuscitation room and began to deteriorate rapidly. The resident's bloodwork showed critical levels with the sodium level low at 120, his potassium level was high at 6.6, and 7.5 readings, white blood cell count was 25.6, and his cardiac treponin level was at 14.65. The resident's blood pressure remained low despite treatment. The resident stopped breathing and had no pulse and CPR was started at 5:25 p.m. and was unsuccessful, efforts ceased at 6:06 p.m., the resident expired. Under primary impression Hyperkalemia (high potassium level) and under additional impressions was NSTEMI (Non-ST Elevated Myocardial Infarction), Hyponatremia (low sodium level), Urinary tract infection with hematuria, acute kidney failure, cardiac arrest, and death. Further review revealed the documentation reflected the resident was thought to have urosepsis (serious infection caused by bacteria from the urinary tract invading the bloodstream) that progressed to multiorgan failure. And . he was seriously ill when he arrived and we were unable to resuscitate him due to the severity of his illness. Other possibilities in the differential diagnosis are MI (Myocardial Infaction), acute kidney injury, congestive heart failure, aortic dissection.</p> <p>Review of Digoxin at <a href="https://www.drugguide.com/ddo/view/[NAME]-Drug-Guide/51218/all/digoxin#:~:text=Hold%20dose%20and%20notify%20health,rhythm%2C%20or%20quality%20of%20pulse.Hold dose and notify health care professional if pulse rate is <60 bpm in an adult Notify health care professional promptly of any significant changes in rate, rhythm, or quality of pulse.">https://www.drugguide.com/ddo/view/[NAME]-Drug-Guide/51218/all/digoxin#:~:text=Hold%20dose%20and%20notify%20health,rhythm%2C%20or%20quality%20of%20pulse.Hold dose and notify health care professional if pulse rate is <60 bpm in an adult Notify health care professional promptly of any significant changes in rate, rhythm, or quality of pulse.</p> <p>In an interview on [DATE] at 3:15 p.m. the DON stated he completed in-services with staff as soon as the issue with Resident #1's blood pressure parameters and change of condition was identified and the facility was working on a performance improvement plan. The DON stated somehow Resident #1's digoxin orders were changed but when they were changed the second time, the vital sign entry was dropped somehow from the MAR and the DON was not sure how and was still investigating. The DON stated he was still working on further interventions but had already started in-services on change of condition and other training for staff and additionally did a 1 on 1 in-service with LVN A and RN B who cared for Resident #1 on [DATE]. The DON provided copies of what was completed so far. The DON stated it was still in process, but in-services started on [DATE].</p> <p>In an interview on [DATE] at 4:15p.m., the MD stated Resident #1 had an unfortunate event of rapid onset sepsis and his dose of digoxin was negligible and had no bearing on the events that sent the resident to the hospital. The MD stated the resident had significant comorbidities that contributed to his illness and being sent to the hospital. When asked what his expectation was for taking blood pressure and pulse readings prior to administration of midodrine and or digoxin medications with ordered parameters, the MD stated in an ideal world, in an ideal situation it would be nice but it did not contribute to the resident going to the hospital. When asked if the expectation were that vital signs were taken and documented as ordered the MD stated again in an ideal situation it would be nice. The MD stated there was no harm to the resident from the vital signs not being documented and again stated this was an unfortunate rapid event brought on by the resident's significant medical and surgical history.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on [DATE] at 5:10 p.m., RN B stated Resident #1 was alert and oriented and complained of nausea, was medicated as ordered and it was effective. It was not until [DATE] that it was not effective but she contacted the provider and got the order to increase the Zofran to 8mg. RN B stated she thought it was effective at first because the resident was sleeping but someone woke the resident up shortly after. RN B stated the resident told her he thought the foley catheter needed to be changed again because it was not draining as much, and RN B replaced the foley catheter. RN B stated the same thing happened with the foley catheter previously and the resident was complaining of bladder spasms so she was waiting to see if the foley catheter would start draining better when his bladder spasms were over but he was being monitored and the resident was the same and at his baseline. RN B stated the resident's family member was at the bedside as well and the resident denied any pain to his bladder area and had just reported bladder spasms. RN B stated she passed on the information in report and her and LVN A looked at the foley catheter during shift change report. RN B stated there was a small amount of urine in the tubing and bag but not more than 100ml. RN B stated in general if a CNA or someone else took vital signs it was given to the nurse on paper.</p> <p>In an interview on [DATE] at 6:00 p.m., LVN A stated Resident #1 had 600ml of urine output that was clear and orange in color with no sediment in the tubing or bag the night before ([DATE]) the resident was sent to the hospital. LVN A stated the resident was alert and oriented to person, place, and time. The resident received therapy for his sacral wound when she walked into the room and stated she would come back when therapy was finished. LVN A stated when the resident did not have any urine output, she bladder scanned the resident and it read there was 0 ml's of urine in the bladder. LVN A stated she explained to the resident and his family member Resident #1 needed to go to the hospital for higher acuity care due to not having any urine output and the resident and his family member were against the resident going to the hospital, but she continued to explain it was serious. LVN A stated the resident and his family member did not want to go to a government hospital as the resident had a bad experience in one about a year ago. LVN A stated the resident and his family member agreed to Resident #1 going to the hospital but not by EMS and agreed to go by regular transport ambulance. LVN A stated she contacted the facility contracted ambulance company and they told her it would be 1.5 hours before they could get there. LVN A stated she immediately hung up and called 911 and was texting the NP at the same time. LVN A stated she noted a color change to the resident just prior to calling 911. LVN A stated she attempted with 3 different blood pressure machines to get a blood pressure but was having difficulty and was not sure the ,d+[DATE] was correct but EMS arrived by that time and took over assessing the resident. LVN A stated Resident #1 was alert and at his baseline the entire time and Resident #1 told her [LVN A], you can fix this, I know you can and LVN A stated she continued to tell the resident he required higher level care. LVN A stated when EMS arrived the resident was alert and oriented to person, place and time and remained at his baseline when he was transferred to the hospital. LVN A stated she wrote notes down on a piece of paper she carried with her during her shift but did not have the sheet anymore and shredded them prior to leaving but that was where the vital signs were usually written until transferred to the computer especially if another staff member had taken a blood pressure or pulse or if she was really busy . LVN A stated she stayed late to document but her assessment and interventions such as bladder scanning might not have been documented because she was busy and ran out of time. LVN A stated other than the low blood pressure at the time of the resident's transfer she was unsure of any low blood pressure issues and would have been notified by the medication aide giving the digoxin but that would have been most likely on paper if it was low and would have been taken again to confirm.</p> <p>In An Attempted Telephone Interview On [DATE] at 7:13 p.m., CMA C was called with no answer. A message was left to return call.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on [DATE] at 3:10 p.m., the PH stated she thought it was between visits the parameters were dropped. The PH stated he always made sure the BP meds or antiarrhythmics had the correct parameters. The PH didn't make a recommendation for his parameters which meant when he reviewed the EMARs it would have had them. There's a digoxin order for February, it has parameters. The midodrine was PRN and it said to give if SBP was less than 100. In February, the last time the PH did a review of the orders and MARS the dig had parameters and the midodrine was PRN and had parameters. The dig order was changed in March, the new order, the digoxin order had parameters until the resident was discharged and the midodrine was still PRN if SBP was less than 100. If the hold parameters were missing, that was a recommendation he always made. These two particular meds should always have parameters. He would have recommended parameters for digoxin HR less than 60 to hold and midodrine for scheduled it depended on the resident and MD orders. For digoxin across the board, it's held for less than 60. Sometimes the MDs would have different parameters (patient specific based on their current condition), but if there were no hold parameters, the PH always recommended adding hold parameters. Digoxin - if HR was less than 60 it could possibly lower the heart rate more. Midodrine - it should only be given if the B/P was low if the B/P was low and it wasn't given the B/P would most likely stay low or could go lower. It won't necessarily go lower, but it won't raise it to normal levels.</p> <p>Record review of staff in-service training provided by the DON reflected a Process improvement for residents, dated [DATE], and included add urine output monitoring to all residents with urinary catheters, Audit completed [DATE]. Inservice staff on new output monitoring process. Daily vitals for VA (Veterans Administration) residents, Audit completed [DATE]. Audit all residents on digoxin for heart rate parameters complete [DATE]. In-service nurses on heart rate parameters. Audit of B/P parameters on all residents complete [DATE]. Audit of B/P parameters on all residents complete [DATE]. Inservice nurses on B/P parameters. In-service LVN A and RN B on acute change of condition and resident assessment. IDT meeting to evaluate process after resident refuses treatment for infection. Plan twice a week minute meetings with nurse to review body system specific assessments (Tuesday/Thursday). Plan to start mock rapid response drills with nurses, mock crash cart equipment obtain and teaching mannequin obtained, will begin collecting written material [DATE] with goal to begin mock codes by [DATE]st. With this document were signed staff training attendance sheets for digoxin heart rate parameters and all B/P medications must have B/P and heart rate parameters dated [DATE] and signed by 17 staff members. Signed staff training dated [DATE] for urinary catheter output monitoring signed by 43 staff members. Signed staff training dated [DATE] for LVN A and LVN B for acute change of condition and resident assessments signed by both LVN A and LVN B. Signed staff training dated [DATE] which included care profile, Kardex, every shift charting, output monitoring, heart rate and B/P parameters and signed by 49 staff members.</p> <p>Record review of the facility's policy on medication administration, dated ,d+[DATE], indicated the policy: .It is the policy of this facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant . 2. Medications must be given in accordance with the resident's service plan. 3. Medications must be administered in accordance with the written orders of the attending physician.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the facility policy on significant change of condition response, revised on ,d+[DATE], indicated it is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care . 1. If at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the licensed nurse or nurse supervisor should be made aware. Examples would be the following (but not limited to): Change or a trending change in vital signs, to include temperature, pulse, blood pressure, heart rate, and oxygen saturation . Change in ability to eat or drink . changes in weight or intake . New complaints of pain or worsening pain . Change in output (bowel and bladder) including amount, color . 2. The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. 3. The resident will then be placed on the 24-hour report and nursing will provide no less than 3 days of observation, documentation, and response to any interventions</p> <p>This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The Administrator and DON were notified. The Administrator was provided with the IJ template on [DATE] at 8:51 p.m.</p> <p>The following Plan of Removal submitted by the facility was accepted on [DATE] at 10:35 a.m.</p> <p>[Facility Name]</p> <p>Plan of Removal</p> <p>Version 2</p> <p>F684: [DATE]</p> <p>Per the information provided in the IJ Template given on [DATE], the facility failed to ensure Resident #1 received treatment and care in accordance with professional standards of practice for quality of care.</p> <p>1. The medical director was notified at 10:11 pm on [DATE]. The pharmacist was notified at 10:13 pm on [DATE].</p> <p>2. Resident #1 is no longer in the facility. Resident #1 was discharged to the hospital on [DATE] at 3:20 pm.</p> <p>3. 100% audit on residents who require medications with parameters was completed by [DATE] by DON/designee.</p> <p>4. New orders, Change of Condition progress notes, and 24-hour report for any parameter triggers of medications will be reviewed daily by DON or designee. Results of these audits will be taken to monthly QAPI for tracking, trending, and recommendations.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Kirkwood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2590 Loop 337 N New Braunfels, TX 78130	
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>5. In-servicing began on [DATE] for Licensed nurses and CMA's to include anti-arrhythmias and hypotensive meds with parameters and will be completed by [DATE]. Any employee not in facility will receive in service via phone, any employee who has not received in-service will not be allowed to work until in-service has been received. In-servicing completed by DON/designee. The staffing roster will be assessed daily prior to each shift by the ED/DON or designee to ensure compliance. No nursing or CMA staff will work the floor prior to completing the required trainings.</p> <p>6. Education to Nursing staff on COC policy and completion of COC's began on [DATE] and will be completed by [DATE]. Any employee not in facility will receive in service via phone, any employee who has not received in-service will not be allowed to work until in-service has been received. In-services completed by DON/designee. The staffing roster will be assessed daily prior to each shift by the ED/DON or designee to ensure compliance. No nursing or CMA staff will work the floor prior to completing the required trainings.</p> <p>7. In-service charge nurses and nurse managers on utilization of the dashboard to assess for parameter alerts requiring follow up while on duty by DON/designee beginning [DATE] and will be completed [DATE]. Any employee not in facility will receive in service via phone, any employee who has not received in-service will not be allowed to work until in-service has been received. The staffing roster will be assessed daily prior to each shift by the ED/DON or designee to ensure compliance. No nursing or CMA staff will work the floor prior to completing the required trainings.</p> <p>8. Medical director or designee to review all anti-arrhythmia and hypotensive meds with parameters by [DATE].</p> <p>9. Incorporate findings and improvements into the facilities QAPI program to ensure sustained compliance and adherence to medication parameters alerts and policies monthly in QAPI for 90 days until on-going compliance confirmed.</p> <p>Monitoring of the POR included the following :</p> <p>In interviews on [DATE] starting at 7:30 p.m. with 2 CMA's, 4 CNA's, 3 LVN's, 1 RN, and LVN A all confirmed they were trained on change of condition, B/P and pulse readings, and urinary output monitoring. The CNA's and CMA's were able to describe different scenarios where the nurse would be notified and things to look for that were out of baseline for the residents. The CMA's were able to state holding medications where vital signs were outside the ordered parameters and notifying the nurse and stated digoxin always had to have a pulse before administering the medication. All licensed staff interviewed confirmed they were trained and were able to state assessments and documentation to be done and when to contact the physician.</p> <p>In an interview with the Medical Director on [DATE] at 3:41 p.m. the Medical Director stated he was notified of the IJ yesterday ([DATE]).</p> <p>In an interview with the Pharmacist on [DATE] at 5:02 p.m. the Pharmacist stated she was notified of the IJ yesterday.</p> <p>Record review of the electronic medical record reflected Resident #1's status as discharged [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A record review and interview with the DON on [DATE] at 1:51 p.m. revealed the DON completed an audit on [DATE] of 12 residents who required medications with parameters.</p> <p>A record review and interview with the DON on [DATE] at 1:51 p.m. revealed the DON reviewed new orders, change of condition progress notes and the 24-hour report on [DATE].</p> <p>[DATE]</p> <p>Monitoring of residents with high-risk medications was completed by the DON on [DATE] and [DATE].</p> <p>In an interview with the DON and Administrator on [DATE] at 1:52 a.m. revealed in-services were completed as staff arrived for work on [DATE]. Staff who were not on shift were called in to be in-serviced or in-serviced via phone.</p> <p>Record review of in-service materials and sign in sheets for clinical staff included 21 in person in-services and 10 via phone.</p> <p>Observation of a sign on the front door informing staff must receive training before returning to work.</p> <p>Staff interviewed on [DATE] at 2:08 p.m. to 3:34 p.m., included:</p> <p>RN - 1; LVN - 5; CMA - 2 . The staff confirmed they had been trained on COC, Response policy/procedure and Medication Parameters, Vital Sign Alert Follow Up, and Dashboard Utilization.</p> <p>Staff interviews on [DATE] included: 3 on the 6 am - 2 pm shift; 3 on 6 am - 6 pm shift; 1 on the 2 pm - 10 pm shift; and 3 on the 6 am - 10 pm. The staff interviewed confirmed they had been trained on COC, Response policy/procedure and Medication Parameters, Vital Sign Alert Follow Up, and Dashboard Utilization. There were no CMAs scheduled for the 10 pm - 6 am shift, calls to 4 LVNs on the 10 pm - 6 am shift were made, there were no answers and voicemails were left for all 4.</p> <p>2 interviews with 10 pm - 6 am shift LVNs were completed at 2:46 pm and 2:50 pm on [DATE]. The staff interviewed confirmed they had been trained on COC, Response policy/procedure and Medication Parameters, Vital Sign Alert Follow Up, and Dashboard Utilization.</p> <p>Record review of Nurses & CMA's roster included a total of 47 clinical staff.</p> <p>In-service materials and sign in sheets for clinical staff included 21 in person in-services and 29 via phone, which included 4 nurses that were not included on the roster.</p> <p>In-service material included Significant Change of Condition, Response policy/procedure and Medication Parameters, Vital Sign Alert Follow Up, and Dashboard Utilization.</p> <p>A record review and interview and with the DON on [DATE] at 1:51 p.m. revealed the DON completed and documented a review with the Medical Director on [DATE] for the 12 residents who required anti-arrhythmia and hypotensive medications with parameters.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of QAPI Agenda, dated [DATE], included the following signatures: Administrator, DON, Clinical Market Leader, Market Leader, Medical Director, ADON, Maintenance Director, Therapy Director, and MDS Nurse.</p> <p>An I [TRUNCATED]</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031</p> <p>Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 6 residents (Resident #1), reviewed for medication errors.</p> <p>1. The facility staff failed to hold Resident #1's digoxin (medication used to manage and treat heart failure and certain abnormal heart rhythms) per physician ordered parameters on 2/18/24 and 2/25/24.</p> <p>2. The facility staff failed to administer Resident #1's midodrine (medication used to raise abnormally low blood pressure) as ordered to be given PRN every 8 hours for SBP<100 on 2/11/24, 2/18/24, 2/25/24, 3/3/24, and 3/13/24 (5 instances) when the resident's SBP was below 100.</p> <p>These failures could place residents at risk of a critically low pulse and blood pressures, inadequate blood flow, missed signs and symptoms of illness, hospitalization , and death.</p> <p>The findings were:</p> <p>Closed record review of Resident #1's face sheet, dated 3/24/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included osteomyelitis, unspecified (a serious infection of the bone that can be either acute or chronic), unspecified atrial fibrillation (an irregular and often rapid heart rhythm), atherosclerotic heart disease of native coronary artery without angina pectoris (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of the coronary artery without chest pain or discomfort), and acute kidney failure (sudden or rapid failure of the kidneys being unable to filter waste products from the blood). The resident was discharged to the hospital by EMS on 3/13/24.</p> <p>Closed record review of Resident #1's care plan reflected a focus, initiated on 12/20/23, for Digoxin therapy related to Heart Failure with an intervention to report to the physician any anorexia, nausea, vomiting, diarrhea, or visual disturbances. Another focus initiated on 12/20/23 for an indwelling foley catheter with multiple interventions included to monitor, record, and report to the MD no urine output and an increased pulse.</p> <p>1. Closed record review of Resident #1's physician orders reflected an order with a start date of 2/13/24 for digoxin 0.0625 mg once daily for heart rate, hold for SBP <100 or heart rate < 60. (the medication was scheduled for the administration time of 7:00 a.m.)</p> <p>Closed record review of Resident #1's EHR under the vital signs tab, reflected on 2/18/24 at 8:06 a.m. B/P- 98/58, P-96. On 2/20/24 at 1:53 p.m. B/P- 110/60 with no pulse documented. On 2/25/24 at 8:18 a.m. B/P- 92/62, P-88.</p> <p>Closed record review of Resident #1's EMAR for February 2024 reflected Digoxin was administered on 2/18/24, and 2/25/24.</p> <p>2. 2. Closed record review of Resident #1's physician orders reflected an order with a start date of 12/8/23 for midodrine 2.5mg every 8 hours as needed for low BP, give if SBP<100.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Closed record review of Resident #1's EMAR for February 2024 reflected midodrine spaces for administration and blood pressure documentation were blank for the entire month of February.</p> <p>Closed record review of Resident #1's EMAR for March 2024 reflected midodrine spaces for administration and blood pressure documentation were blank for 3/1/24 to 3/13/24.</p> <p>Closed record review of Resident #1's EMAR for February 2024 reflected on 2/11/24 digoxin was held for B/P- 98/65 and indicated the midodrine should have been administered per ordered parameters.</p> <p>Closed record review of Resident #1's EHR under the vital signs tab, reflected midodrine should have been administered per ordered parameters on 2/18/24 at 8:06 a.m. B/P- 98/58, 2/25/24 at 8:18 a.m. B/P- 92/62, 3/3/24 at 8:27 p.m. B/P- 92/86, and 3/13/24 at 3:30 p.m. B/P-56/40.</p> <p>Record review of the facility's policy on medication administration, dated 7/2017, indicated the policy: .It is the policy of this facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant . 2. Medications must be given in accordance with the resident's service plan. 3. Medications must be administered in accordance with the written orders of the attending physician.</p> <p>https://www.mayoclinic.org/drugs-supplements/digoxin-oral-route/precautions/drg-20072646?p=1 for digoxin . It is very important that your doctor check your progress closely while you are using this medicine to see if it is working properly and to allow for a change in the dose. Blood tests may be needed to check for any unwanted effects.Watch for signs and symptoms of overdose while you are taking this medicine. Follow your doctor's directions carefully. The amount of this medicine needed to help most people is very close to the amount that could cause serious problems from overdose. Some early warning signs of overdose are confusion, loss of appetite, nausea, vomiting, diarrhea, or vision problems. Other signs of overdose are changes in the rate or rhythm of the heartbeat (becoming irregular or slow), palpitations (feeling of pounding in the chest), or fainting.Check with your doctor immediately if any of the following side effects occur: Dizziness, fainting, fast, pounding, or irregular heartbeat or pulse, slow heartbeat.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031</p> <p>Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 1 of 6 residents (Resident #1) reviewed for medical records.</p> <p>1. The facility staff failed to document a blood pressure and a pulse prior to or after administration of Resident #1's digoxin (medication used to manage and treat heart failure and certain abnormal heart rhythms) that had ordered parameters to hold the medication if the blood pressure or pulse was outside of the parameters from 2/13/24 to 2/17/24, 2/19/24 to 2/24/24 and 2/26/24 to 3/13/24 (23 days).</p> <p>2. The facility staff failed to document a blood pressure for Resident #1's midodrine (medication used to treat abnormally low blood pressure) every 8 hours as ordered to be given PRN every 8hours for low blood pressure from 2/1/24 to 2/29/24 (all of February), and 3/1/24 to 3/13/24 (13 days).</p> <p>These failures could place residents at risk for decreased continuity of care, inaccurate health assessments, medication administration errors and could result in missed signs and symptoms of illness.</p> <p>The findings were:</p> <p>1. Closed record review of Resident #1's face sheet, dated 3/24/24, reflected = a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included osteomyelitis, unspecified (a serious infection of the bone that can be either acute or chronic), unspecified atrial fibrillation (an irregular and often rapid heart rhythm), atherosclerotic heart disease of native coronary artery without angina pectoris (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of the coronary artery without chest pain or discomfort) and acute kidney failure (sudden or rapid failure of the kidneys being unable to filter waste products from the blood). The resident was discharged on [DATE].</p> <p>Closed record review of Resident #1's care plan reflected a focus initiated on 12/20/23 for Digoxin therapy related to Heart Failure with an intervention to report to the physician any anorexia, nausea, vomiting, diarrhea, or visual disturbances. Another focus was initiated on 12/20/23 for an indwelling foley catheter with multiple interventions that included to monitor, record, and report to MD no urine output and an increased pulse.</p> <p>Closed record review of Resident #1's admission MDS assessment, dated 12/14/23, indicated the resident had a BIMS of 11/15, which indicated the resident had moderate cognitive impairment, had a foley catheter, and used a wheelchair.</p> <p>Closed record review of Resident #1's physician orders reflected an order with a start date of 2/13/24 for digoxin 0.0625 mg once daily for heart rate, hold for SBP <100 or heart rate < 60. (the medication was scheduled for the administration time of 7:00 a.m.)</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Closed record review of Resident #1's EMAR for February 2024 reflected Resident #1's digoxin was documented as administered by CMA C on 2/13/24 to 2/16/24, 2/19/24 to 2/24/24 and 2/26/24 to 2/29/24 without documentation of the blood pressure or pulse readings, and documented as administered by CMA D on 2/17/24 without documentation of the blood pressure or pulse readings.</p> <p>Closed record review of Resident #1's EMAR for March 2024 reflected Resident #1's digoxin was documented as administered by CMA C on 3/1/24, 3/4/24 to 3/8/24 and 3/11/24 to 3/13/24 without documentation of the blood pressure or pulse readings.</p> <p>Closed record review of Resident #1's EHR under the vital signs tab, reflected there were 4 blood pressure and 3 pulse readings from 2/13/24 to 2/29/24. The documentation was as follows: on 2/18/24 at 8:06 a.m. B/P- 98/58, P-96. On 2/20/24 at 1:53 p.m. B/P- 110/60 with no pulse documented. On 2/25/24 at 8:18 a.m. B/P- 92/62, P-88.</p> <p>Closed record review of Resident #1's EHR under the vital signs tab, reflected there were 2 blood pressure and 1 pulse reading for March 2024. The Documentation was on 3/3/24 at 8:27 p.m. B/P- 92/86, P- 97. On 3/13/24 at 3:30 p.m. B/P-56/40 with no pulse documented.</p> <p>2. Closed record review of Resident #1's physician orders reflected an order with a start date of 12/8/23 for midodrine 2.5 mg every 8 hours as needed for low BP, give if SBP<100.</p> <p>Closed record review of Resident #1's EMAR for February 2024 reflected midodrine spaces for administration and blood pressure documentation were blank for the entire month of February.</p> <p>Closed record review of Resident #1's EMAR for March 2024 reflected midodrine spaces for administration and blood pressure documentation were blank for 3/1/24 to 3/13/24.</p> <p>Closed record review of Resident #1's EHR under the vital signs tab, reflected from 2/1/24 to 2/12/24 and 2/18/24, 2/20/24, 2/25/24, 3/3/24, and 3/13/24 there was only 1 B/P documented daily. No B/P was documented in the resident EHR for 2/13/24 to 2/17/24, 2/19/24, 2/21/24 to 2/24/24, and 2/26/24 to 3/3/24, and 3/4/24 to 3/13/24 (27 days of February and March).</p> <p>In an interview on 3/22/24 at 3:15 p.m., the DON stated he completed in-services with staff as soon as the issue with Resident #1's blood pressure parameters was identified, and the facility was working on a performance improvement plan. The DON stated somehow Resident #1's digoxin orders were changed but when they were changed the second time, the vital sign entry was dropped somehow from the MAR and the DON was not sure how and was still investigating. The DON provided copies of what was completed so far. The DON stated it was still in process but in-services had started on 3/20/24.</p> <p>In an interview on 3/22/24 at 4:15 p.m., the MD stated when asked what his expectation was for taking blood pressure and pulse readings prior to administration of midodrine and or digoxin medications with ordered parameters in an ideal world, in an ideal situation it would be nice but it did not contribute to the resident going to the hospital. When asked if the expectation were that vital signs were taken and documented as ordered the MD stated again in an ideal situation it would be nice. The MD further stated there was no harm to the resident from the vital signs not being documented and again stated this was an unfortunate rapid event brought on by the resident's significant medical and surgical history .</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 3/22/24 at 5:10 p.m., RN B stated vital signs were taken as ordered and as needed. RN B stated in general if a CNA or someone else took vital signs it was given to the nurse on paper.</p> <p>In an attempted telephone interview on 3/22/24 at 7:13 p.m., CMA C was called with no answer. A message was left to return call.</p> <p>Record review of the facility policy on medication administration, dated 7/2017, indicated . It is the policy of this facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant . 2. Medications must be given in accordance with the resident's service plan. 3. Medications must be administered in accordance with the written orders of the attending physician.</p>