STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455732	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkwood Manor	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)
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** 39049 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assured accurate administering of all drugs to meet the needs of residents for 1 of 8 residents (Resident #1) reviewed for pharmaceutical services, in that: The facility did not reorder Resident #1's Anastrozole for chemo treatment timely, resulting in Resident #1 missing 3 doses (06/21/24, 06/22/24, and 06/23/24) of Anastrozole. The noncompliance was identified as PNC. The PNC began on 06/24/2024 and ended on 06/25/2024. The facility had corrected the noncompliance before the survey began. These failures could place residents who receive medications administered by the facility at risk of not receiving the intended therapeutic benefit of their medication. The findings included: Record review of Resident #1's face sheet, dated 01/10/2025, revealed she was a [AGE] year-old female who originally admitted to the facility on [DATE], readmitted to the facility on [DATE], and discharged on [DATE] to the home with diagnoses that included type 2 diabetes mellitus (trouble controlling blood sugar and using it for energy), atrial fibrillation (abnormal electrical impulses), heart failure (heart muscle does not pump blood), chronic kidney disease stage 3 (less able to filter waste and fluid of your body), and hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body). Record review of Resident #1's discharge MDS assessment, dated 06/24/2024, revealed Resident #1 had a BIMS score of 14, indicating no cognitive impairment. Record review of Resident #1's physician order, dated 05/24/2024, revealed the resident had the order of Anastrozole oral tablet 1 mg (Anastrozole) Give 1 tablet by mouth one time a day for chemo treatment. Record review of Resident #1's Medication Administration Record, dated from 06/01/2024 to 06/30/2024, revealed Resident #1 did not receive Anastrozole oral tablet 1 mg (Anastrozole) on 06/21/24, 06/22/24, and 06/23/24 because the medication was not available. (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	Record review of Medication Error Report, dated 06/24/2024, revealed the facility DON completed Medication Error Report for missing 3 doses of Resident #1's Anastrozole on 06/21/24, 06/22/24, and 06/23/24 because the medication was not available, and corrective actions taken were conducting audit with medications to all residents, counseling with nurses involves, in-services to nursing staff regarding medication refill on time, and revised daily audit process. Record review of the facility investigation report, dated 06/25/2024, revealed the facility DON notified Resident #1's oncologist regarding the resident not receiving Anastrozole for 3 days, and the oncologist stated missing 3 doses has no harmful side effects and to just continue taking it as scheduled, and the medication is completely separate from the resident's chemo and no bearing on the resident's ability to start back up on chemo treatment. Record review the facility's in-service, dated 06/24/2024, revealed the facility DON completed providing in-services regarding re-ordering meds, med not available, missing meds and notifying to physician if meds not available to all nursing staff (nurses, medication aides, and CNAs). During an interview on 01/10/2025 at 1:39 p.m. with LVN-A, he stated he could not remember what reason was for not giving Anastrozole to Resident #1 on 06/21/2024 because it was happened almost one year ago and he did not work the facility anymore. If some medication was not available, LVN-A generally went to the facility emergency kit and took the medication. If the emergency kit did not have the medication, he generally called to pharmacy and DON or ADON to ask, but for this particular situation, LVN-A did not remember. During an interview on 01/10/2025 at 1:08 p.m. with the facility medical director, he stated he remembered Resident #1's 3 days missing doses of the resident's Anastrozole because the facility DON called and reported, and 3 days missing did not affect anything to the resident because the medication (Anastrozole) was only preventive medication. The main purpose of the medication was prophylactic (intended to prevent disease) effect. The medical director reviewed the correction actions from the facility after this incident occurred and no issues were noted. During an interview on 01/10/2025 at 1:00 p.m. with the DON, the DON said that when the DON performed Resident #1's discharge on 06/24/2024, the DON found the resident did not receive her Anastrozole on 06/21/2024, 06/22/2024, and 06/23/2024 because the medication was not available. The DON talked to nurses who worked on those dates, and the nurse was LVN-A. The LVN-A was an agency nurse and did not report regarding the medication not being available to the DON or ADON. The DON called to the agency and said the nurse could not work at the facility anymore. The DON also called to the resident's oncologist and notify it. The oncologist said 3 days missing of the medication did not affect the resident's condition. Resident #1 did not have any negative or adverse reaction based on the resident's assessment on 06/24/2024. The DON conducted and completed providing in-services regarding re-ordering meds, med not available, missing meds and notifying to physician if meds not available to all nursing staff (nurses, medication aides, and CNAs) on 06/24/2024 and 06/25/2024. The DON and ADON also checked all nursing and medication carts and found all medications were available. The DON conducted spot checks and audit randomly if nurses followed the directions the DON provided to the in-service, and no issues noted so far. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, tiled Medication ordering and receiving from pharmacy provider, dated 11/13/2018, revealed Repeat medications (refills) are (written on a medication order from/ordered by peeling the top label from the physician order sheet and placing it in the appropriate area on the order form) provided by the pharmacy for that purpose and ordered as follows: a) reorder medication (seven) days in advance of need to assure an adequate supply is on hand. b) the nurse who reordered the medication is responsible for notifying the pharmacy of changed in directions for use or previous labeling errors. c) the refill order is called in, faxed, or otherwise transmitted to the pharmacy.