

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455876	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  The Woodlands Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4650 S Panther Creek Dr The Woodlands, TX 77381	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 10 residents (Resident #1) reviewed for pharmaceutical services.</p> <p>RN A failed to request a refill of Resident #1's prescribed Testosterone medication (administered every two weeks) timely and resulted in a missed dose on 03/25/2025 until one week later (04/01/2025).</p> <p>This failure placed residents at risk of experiencing worsening symptoms/conditions, pain, and possible infection from missed doses of prescribed medication.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 04/03/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with Multiple Sclerosis (a disease in which the immune system eats away at the protective covering of nerves), quadriplegia (paralysis in all four limbs), neuralgic amyotrophy (multifocal inflammatory neuropathy that usually affects the upper limbs), neuromuscular dysfunction of bladder (urinary bladder problems due to nerve damage or injury), and essential hypertension (a chronic cardiovascular disease that causes abnormally high blood pressure for unknown reasons).</p> <p>Record review of Resident #1's quarterly MDS dated [DATE] revealed he had a BIMS score of 15 (cognitively intact); Resident #1 did not exhibit behaviors related to hallucinations, delusions, behavioral symptoms, or rejection of care; Resident #1 was wheelchair bound (motorized); Resident #1 was dependent on staff for oral hygiene, toileting hygiene, showers, dressing, and personal hygiene; Resident #1 had an indwelling catheter; Resident #1 was always incontinent of bowel; and Resident #1 occasionally experienced pain.</p> <p>Record review of Resident #1's care plan revised on 03/14/2025 revealed the following care areas:</p> <p>*</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident has an ADL self-care performance deficit related to Multiple Sclerosis, HTN, depression (a group of conditions associated with the elevation or lowering of a person's mood): Goal included: The resident will maintain current level of function in ADL's. Interventions included: Resident with low air mattress with bolters. Resident may use enabler as indicated for bed mobility. Transfers: The resident requires mechanical lift with x 2 staff assistance. Bathing/Showering: The resident requires total assistance with 2-person assistance with bath/shower 3x per week and as necessary. Toilet Use: The resident requires extensive assistance of 1 person for incontinence care.</p> <p>*</p> <p>The resident has potential for exhibiting attention for sexual inappropriate behaviors towards females. Goal included: The resident will have no evidence of behavior problems. Interventions included: If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others.</p> <p>Record review of Resident #1's physician's orders for March 2025 revealed:</p> <p>*</p> <p>Testosterone Cypionate 200 mg/ml to inject 1.25 ml IM every 2 weeks in the morning, every 2 weeks on Tuesday for hypogonadism (a failure of the gonads, testes, or ovaries, to function properly). Order date: 09/10/2024. Start date: 09/24/2024.</p> <p>Record review of Resident #1's Mar for March 2025 revealed:</p> <p>*</p> <p>Testosterone Cypionate 200 mg/ml to inject 1.25 ml IM every 2 weeks in the morning, every 2 weeks on Tuesday for hypogonadism. Start date: 09/24/2024. D/C Date: 04/01/2025. The medication was administered as prescribed on 03/11/2025 by RN A. The medication was not given on 03/25/2025. RN A indicated to see the resident's progress notes for the reason why it was not administered.</p> <p>Record review of Resident #1's MAR for April 2025 revealed:</p> <p>*</p> <p>Testosterone Cypionate 200 mg/ml to inject 1.25 ml IM every 2 weeks in the morning, every 2 weeks on Tuesday for hypogonadism. Start date: 04/01/2025. This medication was administered on 04/01/2025.</p> <p>Record review of Resident #1's nursing progress notes for March 2025 revealed:</p> <p>*</p> <p>On 03/25/2025, at 11:45 a.m., RN A wrote, Testosterone Cypionate 200 mg/ml to inject 1.25 ml IM every 2 weeks in the morning, every 2 weeks on Tuesday for hypogonadism pending for pharmacy delivery.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with Resident #1 on 04/03/2025 at 10:00 a.m. revealed he was alert, oriented, and ambulated via motorized wheelchair. He stated RN A did not give him his prescribed testosterone injection two weeks ago until yesterday (04/02/2025, but it was administered on 04/01/2025). He said RN A told him there were no more refills on the injection, so he had to call the pharmacy. He said on the night after he missed the dose, a night nurse told him the medication was available in the building, but nobody offered to give him the injection until 04/02/2025 (it was administered on 04/01/2025). He said he never felt any different from not getting the injection.</p> <p>In an interview with RN A on 04/03/2025, at 11:30 a.m., he stated Resident #1 missed a dose of Testosterone last week because the nurse who administered the last dose did not reorder the medication. He said he did not know who gave Resident #1 the last dose of Testosterone (on 03/11/2025), but then on his shift (on 03/25/2025), there was no medication available to administer. He said he told Resident #1 he would call the pharmacy and get the medication. He said the pharmacy delivered the medication Wednesday night (03/26/2025), but since Resident #1 took the medication every other week, he did not get it until the next Tuesday (04/01/2025). He said usually, he would reorder medication when a resident had one dose left. He said you would not wait to reorder until you administer the last dose of medication because you may not have it in time for the next dose. He said which ever charge nurse saw that the medication was running low should reorder the medication. He said he normally reordered medication through their computer system. He said any negative affects of missing a medication dose would depend on the medication. He said he did not know why Resident #1 was prescribed Testosterone because he was already aggressive. He said he did not think Resident #1 would experience any negative affects from not taking a dose of Testosterone.</p> <p>In a follow-up interview with RN A on 04/03/2025, at 12:30 p.m., he stated, Oh yeah, I remembered what happened. He said he was the last nurse who administered Resident #1's Testosterone. He said he saw it was Resident #1's last dose on 03/11/2025 and he reordered it through the computer system. He said since it was not a daily medication, he did not remember to check on it until it was time to give it again on 03/25/2025. He said he had to call the pharmacy, and then they sent the medication. He said from now on, he will order the medication and call the pharmacy on the same day.</p> <p>In an interview with the DON on 04/03/2025, at 12:40 p.m., she stated she knew the ADON had to reorder the Testosterone because there were no more refills, but she did not know when RN A tried to reorder it and found out that there were no more refills. She said she would contact the pharmacy to find out when RN A placed the order because there was no documentation in Resident #1's progress notes to show when it was done.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON and ADON on 04/03/2025, at 1:30 p.m., the DON said the pharmacy representative told her if any order was made by phone, they did not have a record of it. The ADON said she called the pharmacy on 03/25/2025 to reorder the medication and it was received in the facility and signed for on 03/26/2025, at 1:23 a.m. The DON said she asked RN A about the incident, and he told her he tried to administer the injection the next day on 03/26/2025, but Resident #1 refused. The DON said she had not spoken to RN A about it that day (04/03/2025), but she could not recall the day she spoke with him about it. The DON said RN A had a text message in his phone to Resident #1's NP asking if it was okay to administer the medication on 03/26/2025 (this text nor the answer from the NP were provided during the investigation), but there was no documentation about it in Resident #1's chart. The DON said Resident #1 told her RN A did not offer him the injection on 03/26/2025. The DON said the medication was discontinued on Resident #1's MAR and then restarted the next Tuesday to get him back on the two-week routine. The DON said RN A told her everything was done (the medication was reordered) by phone. The DON said RN A did not tell her he tried to reorder the medication electronically. The ADON said RN A could have pushed the button to reorder the medication through the computer system but since Testosterone was a controlled substance, only she (an ADON) or the DON could have reordered it. The DON said this medication should have been reordered when the last dose was given since it was administered every 14 days. The DON said she was not sure why Resident #1 received Testosterone because he was aggressive. She stated Resident #1 did not experience any negative effects when he missed the dose of medication.</p> <p>An attempt was made to contact Resident #1's NP on 04/03/2025, at 1:43 p.m. A voicemail message was left but the call was not returned prior to the survey exit.</p> <p>Record review of the facility's policy titled, Ordering and Receiving Medications from Pharmacy, revised on 10/01/2019 revealed, . It will be the responsibility of the facility to re-order the medication to avoid any lapse in therapy . 6. Refill Medication Ordering - Maintenance Reorders: . B. The refill order is used for ordering maintenance medications. All refills must be ordered before the last dose is administered. Reorder medications 3 to 4 days in advance of need to assure an adequate supply is on hand .</p>		