STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455910	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Nursing Center	300 Cherry St Chandler, TX 75758

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure a resident who enters the facility with/without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary for 2 of 2 residents (Resident #4 and #74) reviewed for indwelling catheters. The facility did not have an appropriate diagnosis for Residents #4's and #74's Foley catheter. This failure could place residents at risk for inappropriate placement of indwelling catheters, discomfort or injury, and urinary tract infections. Findings included:1. Record review of a face sheet dated 02/19/26 indicated Resident #4 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included myocardial infarction (blood flow decreases or stops in one of the blood vessels of the heart causing tissue death), osteomyelitis (an infection in a bone), hypertension (a condition in which the force of the blood against the artery walls is too high), encephalopathy (a group of disorders that affect the brain and cause altered mental state), and atrial fibrillation (a type of irregular heartbeat). Record review of a physician order dated 11/14/25 indicated Resident #4 was to have a Foley catheter and it was to be changed on the 14th of every month. There was no related diagnosis for indication of the indwelling catheter. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #4 had moderately impaired cognition with a BIMS score of 10 out of 15; she had an indwelling catheter; she did not have renal insufficiency (poor function of the kidneys), neurogenic bladder (lack of bladder control), or obstructive uropathy (blocked kidney tubes); and she did not have a UTI in the last 30 days. Record review of the care plan dated 01/12/26 indicated Resident #4 had alteration inbladder/bowel elimination related to Foley catheter. There was no related diagnosis for indication of the indwelling catheter. During an observation and interview on 02/18/2026 at 02:28 p.m., the TX Nurse said Resident #4 had the Foley inserted due to the pressure wounds on her bottom as well as issues with retaining urine. 2. Record review of a face sheet dated 02/19/26 indicated Resident #74 was a [AGE] year-old male admitted on [DATE]. His diagnoses included quadraplegia (symptom of paralysis that affects all a person's limbs and body from the neck down), kidney failure (condition where the kidney reaches advanced state of loss of function), and obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). Record review of a physician order dated 09/09/25 indicated Resident #74 was to have a Foley catheter and it was to be changed every month. There was no related diagnosis for indication of the indwelling catheter. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #74 had moderately impaired cognition with a BIMS score of 12 out of 15; he had an indwelling catheter; he had obstructive uropathy (blocked kidney tubes); and he did not have a UTI in the last 30 days. Record review of the care plan updated on 02/17/26 indicated Resident #74 had an indwelling catheter related to pressure ulcer. During an observation and interview on 02/19/2026 at 07:28 a.m. wound care Resident #74 provided by the TX Nurse. Resident #74 was observed with a Foley catheter. The TX Nurse said because of the pressure wound to his bottom was a healing Stage 4 he had the catheter. During an interview on 02/19/25 at 05:20 p.m. the DON said she had not realized Residents #4's and #74's order for the Foley catheter did (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455910	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Nursing Center	300 Cherry St Chandler, TX 75758

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not have a related diagnosis indicating the reason for the catheter. She said she expected nurses transcribing orders to include an indication for the catheter. During an interview on 02/19/26 at 05:40 p.m. the Administrator said she expected nursing staff to have a diagnosis for use of a catheter. Record review of an undated Urinary Continence and Incontinence-Assessment and Management policy indicated Policy Statement:.4. Indwelling urinary catheters will be used sparingly, for appropriate indications only.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455910	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Nursing Center	300 Cherry St Chandler, TX 75758

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. Based on interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 2 of 4 medication carts (MA Cart #1) and (Nurse Cart #1) observed for controlled medications storage, and failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals to ensure no medication errors and to meet the needs of each resident for 1 of 5 residents (Resident #70) for medication pass. * RN C was observed on 2/19/2026 signing the controlled substance count sheets for the end of their shift at the beginning of their shift on RN Cart #1. * MA D was observed on 2/19/2026 signing the controlled substance count sheets for the end of their shift at the beginning of their shift on MA Cart #1. * Medication reconciliation of the observed medication pass with LVN B indicated she administered a medication to Resident #70 without an order causing an administration error rate of 4%.These failures could place residents at risk for medication diversion, administration of incorrect medication, and compromised resident safety. Findings included: During an observation on 2/19/2026 at 4:30 PM, while doing observation of two of four med carts was discovered that RN C and MA D, were signing on and off at the same time of signing on at shift count, The controlled drugs on hand. During a record review on 2/19/2026 at 4:35 PM, the narcotic count verification sheet read, signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication count is in agreement with the quantity stated on the narcotic count verification sheet. During an interview on 2/19/2026 at 4:40 PM with RN (C) he said, he doesn't usually sign the narcotic count verification sheet in both the on and off slots at the same time along with signing for the next day on and off, this was a mistake he made and should not have signed the sheet and then asked if he should scratch it out, he said, because if the count is wrong he would be responsible if something happens between his shift. During an interview on 2/19/2026 at 4:45 PM with MA (D) she said she doesn't always sign both coming/going slots on the: Nurse on and Nurse off, at the same time, she said knows she shouldn't, because if the count happens to be wrong it will be on her if it could place the resident at risk for receiving or not receiving correct medication. During an interview on 2/19/2026 at 4:50 pm with the ADON and the DON all said each nurse and MA were to sign the Drug Administration Record Controlled Drug Count Record at the time when coming on to their shift and at the time they were going off their shift. The ADON said she had in-serviced all nurses and MAs on the procedure and she was ultimately responsible for monitoring and making sure it was done correctly. Record review of an undated policy and procedure document titled Controlled Substances indicated the facility with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455910	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Nursing Center	300 Cherry St Chandler, TX 75758

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	4. Nursing staff coming on duty and nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. During an observation on 02/18/26 at 08:00 a.m. LVN B reconstituted Ertapenem Sodium Injection powder with Lidocaine 1% liquid 5cc for Resident #70. Record review of February 2026 Physician Orders indicated Resident #70 had an order dated 02/10/26 for Ertapenem Sodium Injection Solution Reconstituted (Ertapenem Sodium) Inject 1 gram intramuscularly one time a day. There was an order dated 09/05/25 for Lidocaine HCl External Pad 4% (Lidocaine HCl) apply to right knee topically as needed for pain or discomfort. There was no order for Lidocaine 1% liquid 5cc to reconstitute the Ertapenem Sodium Injection. During an interview on 02/19/26 at 10:42 a.m. LVN B said she did not realize there was no order for the Lidocaine to reconstitute the injection medication for Resident #70. She said she should clarify the order with the physician. She said the resident could have a reaction to the medication requiring further medical intervention since it was injected. During an interview on 02/19/26 at 05:20 p.m. the DON said there should be an order for the Lidocaine or any injectable solution to reconstitute a powered antibiotic. She said not having an order the medication could get reconstituted with the wrong solution and cause pain or an allergic reaction. During an interview on 02/19/26 at 05:40 p.m. the Administrator said she expected staff to ensure they have an order for medications needed. Record review of an undated Intermuscular Injections policy indicated .Preparation: 1. Verify that there is a physician's medication order for this procedure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455910	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Nursing Center	300 Cherry St Chandler, TX 75758

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 4 residents (Residents #4, #70, and #74) observed for Infection Control. * Residents #4 and #70 had incorrect isolation signage posted on their doors. * CNA A did not don PPE before entering Resident #70's room to deliver her lunch tray and did not wash her hands when leaving the room.* CNA A did not change gloves, sanitize/wash hands between glove changes, and touched clean items with dirty gloves while performing incontinent care on Resident #70 who was in Contact Isolation for ESBL of the urine. * The TX Nurse did not change gloves, sanitize/wash hands between glove changes, and touched clean items with dirty gloves while performing incontinent care on Resident #74 who was in EBP for an indwelling catheter. These failures could place residents who resided in the facility, as well as employees and visitors, at risk of communicable diseases. Findings included:1. Record review of a face sheet dated 02/19/26 indicated Resident #4 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included myocardial infarction (blood flow decreases or stops in one of the blood vessels of the heart causing tissue death), osteomyelitis (an infection in a bone), hypertension (a condition in which the force of the blood against the artery walls is too high), encephalopathy (a group of disorders that affect the brain and cause altered mental state), and atrial fibrillation (a type of irregular heartbeat). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #4 had moderately impaired cognition with a BIMS score of 10 out of 15; she had an indwelling catheter; and she had a wound. Record review of the care plan dated 01/12/26 indicated Resident #4 had colostrum difficile (infectious feces). An intervention included strict contact isolation. During an observation and interview on 02/17/2026 at 11:08 AM Resident #4 had EBP set up and signage on door. She had an indwelling catheter with the collection hanging on the side of the bed. She said she had a wound on her bottom that was being treated. Record review of the Physician Orders for February 2026 indicated Resident #4 had an order dated 02/09/26 for strict contact isolation for diagnosis of colostrum difficile (infectious feces). 2. Record review of a face sheet dated 02/19/26 indicated Resident #70 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included myocardial infarction (blood flow decreases or stops in one of the blood vessels of the heart causing tissue death), osteomyelitis (an infection in a bone), hypertension (a condition in which the force of the blood against the artery walls is too high), encephalopathy (a group of disorders that affect the brain and cause altered mental state), and atrial fibrillation (a type of irregular heartbeat). Record review of the February 2026 Physician Orders indicated Resident #70 had a physician order dated 02/10/26 for strict contact isolation for diagnosis of ESBL in urine. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #70 had severely impaired cognition with a BIMS score of 07 out of 15. Record review of the care plan dated 01/12/26 indicated Resident #70 had urinary tract infection, ESBL with interventions included admit to strict CONTACT isolation for ESBL with single room occupancy. During an observation on 02/17/2026 at 12:05 p.m. Resident #70 had PPE set up outside her room and EBP signage on her door. During an observation and interview on 02/17/26 at 12:10 p.m. CNA A observed entering Resident #70's room with lunch tray (all in styrofoam). There was an EBP sign on resident room door with PPE cart set up outside room. CNA A put no PPE on to deliver lunch tray, sat the tray on the over bed table, and left room without washing her hands. CNA A was asked why Resident #70 was in EBP, she indicated the resident had an infection in her urine. During an observation and interview on 02/18/2026 at 02:28 p.m. of incontinent care provided to Resident #70 by CNA A. While Resident #70 lying on her left side CNA A wiped the resident's buttocks with an incontinent care wipe. CNA A then removed the dirty brief from under the resident and placed it in the biohazard box for trash. Without doffing her dirty gloves, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455910	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Nursing Center	300 Cherry St Chandler, TX 75758

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitizing her hands, and donning clean gloves CNA A opened the closet and obtained a clean brief from one of the shelves. CNA A then placed the clean brief under the resident, rolled the resident to her right side, and pulled the clean brief. CNA A then rolled the resident to her back and closed the brief. CNA A then pulled the resident's gown down and fixed her covers. When asked if she would have done anything different, she said no. When asked was she to change gloves between dirty and clean procedures she said she should have changed her gloves and sanitize her hands after she pulled the dirty brief out and before obtaining the clean brief and putting it on. 3. Record review of a face sheet dated 02/19/26 indicated Resident #74 was a [AGE] year-old male admitted on [DATE]. His diagnoses included quadraplegia (symptom of paralysis that affects all a person's limbs and body from the neck down), kidney failure (condition where the kidney reaches advanced state of loss of function), and obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #74 had moderately impaired cognition with a BIMS score of 12 out of 15; he had an indwelling catheter; and he had a wound. Record review of the care plan updated on 02/17/26 indicated Resident #74 had an indwelling catheter related to pressure ulcer. During an observation and interview on 02/19/2026 at 07:28 a.m. wound care and incontinent care of Resident #74 provided by CNA A and the TX Nurse. CNA A rolled the dirty brief under Resident #74 then CNA A rolled the resident towards her. The TX Nurse removed the dirty brief and placed it in the trash. The TX Nurse then without doffing her dirty gloves, sanitizing her hands, and donning clean gloves she obtained a clean brief from the closet then placed it under the resident. The TX Nurse then rolled the resident on his back and closed one side while CNA A closed the other side of the brief. The TX Nurse said she would not have done anything different. When asked was she to change gloves between dirty and clean procedures she said she should have changed her gloves and sanitize her hands after she pulled the dirty brief out and before obtaining the clean brief and putting it on. During an interview on 02/19/2026 at 07:45 a.m. the ADON was asked for a policy regarding incontinent care. The ADON said staff should always change gloves between dirty and clean procedures and sanitize or wash hands between glove changes when providing care. During an interview on 02/19/26 at 05:20 p.m. the DON indicated gloves were to be changed with hand hygiene between glove changes as required. She said she expected staff to follow policies. During an interview on 02/19/26 at 05:40 p.m. the Administrator indicated she expected staff to follow policies and standards of practice during care. Record review of an undated Handwashing/Hand Hygiene policy indicated .Policy Interpretation and Implementation:.6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations:.b. After contact with a resident with infectious diarrhea including but not limited to infections caused by norovirus, salmonella, shigella, and [colostrum] difficile.7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:.b. before and after direct contact with residents;.h. Before moving from a contaminated body site to a clean body site during resident care.m. After removing gloves; n. Before and after entering isolation precaution settings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455910	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Nursing Center	300 Cherry St Chandler, TX 75758

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received an accurate assessment, reflective of the resident's status for 1 of 24 residents reviewed for accuracy of assessments. (Resident #3) The facility did not accurately complete the MDS assessment to indicate Resident #3 did not use a ventilator (a type of breathing apparatus that provides mechanical ventilation by moving breathable air into and out of the lungs, to deliver breaths to a patient who is physically unable to breathe, or breathing insufficiently). This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings included:Record review of a face sheet dated 02/18/26 indicated Resident #3 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), respiratory failure (a serious condition that makes it difficult to breathe on your own), and obstructive sleep apnea (a common sleep disorder characterized by repeated interruptions in breathing during sleep due to airway blockage). There was no indication of Resident #3 had a tracheostomy (a surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised). Record review of the Physician Orders for February 2026 had no indication Resident #3 had a tracheostomy or utilized a ventilator. Resident #3 had an order dated 09/10/25 for a CPAP (continuous positive airway pressure (a device the provides mild pressure to prevent the airway from collapsing or becoming blocked)) at bedtime. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #3 had under section O0110 Special Treatments, Procedures, and Programs; Respiratory Treatments: F1. Invasive Mechanical Ventilator (ventilator or respirator) was marked as the resident received. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #3 had under section O0110 Special Treatments, Procedures, and Programs; Respiratory Treatments: F1. Invasive Mechanical Ventilator (ventilator or respirator) was marked as the resident received. During an observation and interview on 02/17/2026 at 11:53 a.m. Resident #3 was sitting up in her recliner in her room. She had oxygen on via nasal cannula. She did not have a tracheostomy or a ventilator. She had a CPAP machine at her bedside. She said she did not utilize a ventilator just the CPAP when she needed it. During an observation on 02/18/26 at 10:46 a.m. Resident #3 was in her wheelchair propelling herself in the hallway. She had portable oxygen on through a nasal cannula. During a phone interview on 02/19/26 at 04:20 p.m. the MDS Nurse indicated she reviewed a resident's chart to obtain information as well as speak with staff members to obtain information. She said she marked the wrong box for Resident #3. She said the resident had a CPAP not a ventilator/respirator. She said inaccuracy of the MDS could leave residents not provided the care they need. She said she followed the MDS RAI manual for the MDS. During an interview on 02/19/26 at 005:20 p.m. the DON said she would only check the MDS for completion because she expected staff responsible for them would ensure the information was correct when they put it on the MDS. During an interview on 02/19/26 at 05:40 p.m. the Administrator said she expected staff to be professional and complete information for the clinical record to accurately reflect the residents' needs. Record review of an undated MDS Policy indicated Regarding all matters related to MDS, [company] policy is to follow the RAI manual and federal regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455910	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Nursing Center	300 Cherry St Chandler, TX 75758

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free of significant medication errors for 1 of 3 residents (Resident #70). * LVN B reconstituted Resident #70's Ertapenem Sodium Injection powered antibiotic with Lidocaine 1% Solution and administered IM to Resident #70. There was no physician order for the Lidocaine 1% Solution. This failure could place residents at risk for possible side effects pale, gray, or blue-colored skin, lips, or nails, confusion, headache, lightheadedness, fast heartbeat, or unusual tiredness or weakness of a medication administered without a physician order. Findings included:Record review of a face sheet dated 02/18/26 indicated Resident #70 was a [AGE] year-old female admitted on 0 4/22/25 period Her diagnosis included fracture of the right femur (broken right thigh bone) and urinary tract infection (an infection in the kidneys, ureters, bladder, or urethra).During an observation on 02/18/26 at 08:00 a.m. LVN B reconstituted Ertapenem Sodium Injection powder with Lidocaine 1% liquid 5cc for Resident #70 and she injected it into the resident. Record review of February 2026 Physician Orders for medication reconciliation of medication pass observed indicated Resident #70 had an order dated 02/10/26 for Ertapenem Sodium Injection Solution Reconstituted (Ertapenem Sodium) Inject 1 gram intramuscularly one time a day for infection of the urine. There was an order dated 09/05/25 for Lidocaine HCl External Pad 4% (Lidocaine HCl) apply to right knee topically as needed for pain or discomfort. There was no order for Lidocaine 1% liquid 5cc to reconstitute the Ertapenem Sodium Injection. During an interview on 02/19/26 at 10:42 a.m. LVN B said she thought there was an order for the Lidocaine 1% injectable. She said she did not realize there was no order for the Lidocaine to reconstitute the injection medication for Resident #70. She said she should clarify the order with the physician. She said the resident could have a reaction to the medication requiring further medical intervention since it was injected. During an interview on 02/19/26 at 05:20 p.m. the DON said there should be an order for the Lidocaine or any injectable solution to reconstitute a powered antibiotic. She said not having an order the medication could get reconstituted with the wrong solution and cause pain or an allergic reaction. During an interview on 02/19/26 at 05:40 p.m. the Administrator said she expected staff to ensure they have an order for medications needed. Record review of an undated Intermuscular Injections policy indicated .Preparation: 1. Verify that there is a physician's medication order for this procedure. According to the Mayo Clinic accessed on 02/19/26at https://www.mayoclinic.org/drugs-supplements/lidocaine-injection-route/description/drg-20452273 This medicine may cause a rare, but serious blood problem called methemoglobinemia (cannot bind oxygen, resulting in reduced oxygen delivery to tissues and organs).Methemoglobinemia is a significant condition that can lead to serious health complications if not recognized and treated promptly. Understanding its causes, symptoms, and treatment options is crucial for effective management and prevention of severe outcomes. If you suspect methemoglobinemia, it is essential to seek medical attention for proper diagnosis and treatment The risk may be increased in children younger than 6 months of age, elderly patients, or patients with certain inborn defects. It is more likely to occur in patients receiving too much of the medicine, but can also occur with small amounts. Check with your doctor right away if you or your child has the following symptoms after receiving this medicine: pale, gray, or blue-colored skin, lips, or nails, confusion, headache, lightheadedness, fast heartbeat, or unusual tiredness or weakness.