STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455917	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer Creek of Wimberley	555 Ranch Rd 3237 Wimberley, TX 78676

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070 Based on observations, interviews, and record review, the facility failed to ensure storing all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys , for 1 (Resident #1) of 3 residents reviewed for their controlled drugs storage. The facility failed to ensure one bottle of Hydrocodone and one bottle of Valium of Resident #1 were stored in a separately locked, permanently affixed compartments for storage of controlled drugs. This failure could place residents at risk of not receiving medications due to drug diversion that leads to not achieving the intended therapeutic effects of medications. . The findings included: Record review of Resident #1's face sheet dated 12/04/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and discharged on [DATE] . Her diagnoses were, Unspecified fracture of lower end of left ulna and radius (The two bones of the forearm), Subsequent encounter for closed fracture with routine healing, UTI, Polyneuropathy (a peripheral nerve disease), Unspecified temporomandibular joint disorder (a disease that causes pain and dysfunction of the joints and muscles) and Cognitive communication deficit. Record review of Resident #1's initial MDS assessment, dated 10/28/24 revealed a BIMS score of 13 indicating her cognition was intact. Record review of Resident #1's care plan dated 10/22/24 indicated 1. Resident #1 needed pain management and monitoring related to left ulna and radius fracture and the relevant intervention was administering Pain medication as ordered. 2. Resident #1 had temporomandibular joint disorder and history of taking Valium (2 mg-0.5 mg PRN at bedtime) and the relevant intervention was administering anti-anxiety medications ordered by physician. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's MAR of October 2024 reflected: 1.Pending confirmation : Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen): Give 1 tablet by mouth four times a day for pain -D/C Date- 10/22/2024 19:18. 2. There was no Valium listed in the MAR . The facility incident investigation report dated 11/01/24 revealed, on 10/23/24 Hydrocodone Rx of Resident #1 was missing from med cart. Resident #1's FM dropped off medications on 10/22/24 with admission nurse, RN A. It was stated in the report that RN A notified incoming night nurse RN B that she had placed Hydrocodone bottle in one of the drawers with other non- controlled medications to returning to Resident #1's FM, because RN A found out from Resident #1's medical records that she had an allergy to Hydrocodone and the NP would need to clarify orders. RN A reported RN B assured RN A that she would make the med sheets for it. On 10/23/24, in the morning, MA C found Resident #1's Valium on the top of her med cart . However, there was no Hydrocodone. MA C immediately reported to RN D who was the nurse on duty on 10/23/24 and she made a med sheet for the Valium. Resident #1's FM was contacted to clarify if the Hydrocodone had been picked up, and they confirmed it had not. During a telephone interview on 12/04/24 at 12:55 pm, RN A stated she worked on 10/22/24 in the afternoon shift and was the nurse who admitted Resident #1 to the facility. She stated the family, during admission, brought in medications that included Valium and Hydrocodone. She stated, that evening, she found out from Resident #1's medical records that the resident was allergic to Hydrocodone, and Valium was not listed in the discharge medication sheet. RN A stated she bundled both the bottles with a rubber band and stored in the third drawer of the med cart so that those medications could be returned to the FM the next day in the morning. MA A said she instructed RN B to let the morning nurse know about it so that she could return the medications to the family. However, the next morning, the DON called her and informed her that the Hydrocodone was missing, and the family never received the medication. RN A stated she made a mistake, and she should have stored Hydrocodone and Valium under double lock in the controlled drug compartment instead of storing them with regular medications. She stated it was necessary to enter them in the controlled drug logbook as soon as it was received. RN A said she learned a lesson from this incident and made a point not to repeat the same mistake even again. Phone calls made on 10/22/24 to RN B at 1:08 pm , 2:10 pm and 3:00 pm, and message were left requesting a call back. No returned call was received as of 11/04/24 at 5:00 pm. During an interview on 12/04/24 at 12:25 pm, MA C stated on 10/23/24 at about 9:30 am, she noticed a bottle of Valium sitting at the top of her med cart in Hall 200, and on closer observation, it was revealed that it was for Resident #1, who was admitted on [DATE]. She said she immediately reported to the charge nurse, RN D. MA C said RN D immediately entered the medication in the controlled drug logbook, and then stored the medication in the controlled drug locker inside the med cart. She stated she knew controlled drugs should always be stored under double lock in the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 11:50 am, RN D stated she was the day shift charge nurse on 10/23/24 . She said at about 9:30 am, MA C reported to her that she found a bottle of Valium for Resident #1 sitting on her med cart. RN D stated when she checked the controlled drug logbook, and noticed that the Valium for Resident #1 was not entered in the logbook. She said she immediately entered it in the logbook as witnessed by MA C and stored it in the controlled drug drawer in the MA med cart for Hall 200. RN D stated she reported the incident to the DON immediately. She stated DON asked her to search for Resident #1's Hydrocodone, after talking to RN A over the phone however the Hydrocodone was not found anywhere in the facility. RN D stated she took over the shift on 10/23/24 from the night shift nurse RN B, and RN B did not mention about any of Resident #1's controlled drugs. During an interview on 12/04/24 at 3:00 pm, LVN E stated he worked in the afternoon shift on 10/23/24 and his duty was administering medications . He said, as he heard during the shift changeover that Resident #1's Hydrocodone was not in the facility, he contacted the FM thinking that the Hydrocodone was returned to them. LVN E stated they confirmed to him that the facility never returned any of Resident #1's medication. LVN E stated, most likely the medication missed in the time frame between Resident's admission time on 10/22/24 and the beginning of the morning shift on 10/23/24. He stated the Hydrocodone was not traceable as the staff did not follow the controlled drug policy. The staff had not recorded those drugs in the logbook as soon as they received, also not stored properly in the controlled drug locker in the med cart. During a telephone interview on 12/04/24 at 3:20 pm, the FM of Resident #1 stated the resident was transferred from another facility by her on 10/22/24 in the afternoon. The FM stated she handed over all the medications to the staff on duty on that day including Valium and Hydrocodone. She stated Resident #1 did not have any allergy to Hydrocodone. However, it was not a preferred pain medication by her due to the after effect of the medication. The FM stated the facility called her on 10/23/24 and asked if anyone from facility gave her back the medications. The FM confirmed none of the medications were returned to her. The FM stated she did not think the absence of Hydrocodone affected Resident #1 adversely since she was on other pain medications, Hydrocodone was a newly added medication by her PCP on 10/22/24, and she had not started taking it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 11:30 am, the DON stated Resident #1 was admitted from another facility on 10/22/24 in the afternoon. She said after the completion of the admission of Resident #1 , the FM went home and brought in Resident #1's medications, and that included Valium and newly ordered Hydrocodone. She stated she confirmed with the pharmacy that there were 28 tablets of Hydrocodone in the bottle. The medications were dropped off with the charge nurse RN A who completed the admission process. The DON stated RN A reported to her that she kept the Hydrocodone and Valium to the side for returning to the FM. She stated RN A did not enter Hydrocodone and Valium into the PCC as resident had allergy to Hydrocodone and Valium was not in the list of discharge medications. The DON stated, per RN A, she stored it in the MA med cart on Hall 200, with other non-controlled medications , with the intention to return it to the family. The DON stated RN A did not follow the facility's policy of storing controlled drugs in the locked compartment designated for controlled drugs . The DON stated , RN A reported that she instructed RN B to let the day nurse RN D know about it so that she could return it to the family. The DON stated RN D reported that RN B never talked about Hydrocodone and Valium during the shift change on 10/23/24 in the morning. The DON stated on 10/23/24 in the morning MA C found a bottle of Valium on the top of the med cart in hall 200 , who informed the nurse in charge, RN D. DON stated RN D in turn reported to her and then she immediately started the investigation. The DON stated during her investigation it was revealed that RN A neither entered Hydrocodone and Valium in the controlled drug logbook nor stored under the double lock in the med cart as instructed by facility policy. The DON stated it was also revealed that the night nurse, RN B did not report about the medications to the morning shift nurse RN D . The DON stated the facility conducted a drug test at the facility and the result was negative to all the staff members involved except RN B as RN B refused to undergo the drug test. The DON said after the completion of the facility investigation on 11/01/24 , RN B was terminated from the service and RN A and other staff members had additional training on controlled drugs management. Review of the facility's policy Controlled Substances revised in November 2022 reflected, Policy Statement The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule JJ-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) . 3. Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record . Storing Controlled Substance: Controlled substances are separately locked in permanently affixed compartments , except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected .