

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/01/2024
NAME OF PROVIDER OR SUPPLIER  Lubbock Hospitality Nursing and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04033</b></p> <p>Based on observations, interviews, and record review the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 3 residents (Resident #1) reviewed for pain management.</p> <p>The facility failed to ensure Resident #1 received Hydrocodone-Acetaminophen-Schedule III 300-30 mg tablet every 6 hours-as needed (PRN) for pain on 10/30/24 from 6 A.M. to 1:50 P.M.</p> <p>This failure placed the resident at risk of increased pain and decreased quality of life.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet dated 10/31/24 reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. This report included Resident #1's diagnoses as unspecified pain, atherosclerosis of native arteries of extremities with rest pain to right leg (severe burning pain in your legs and feet that continues even when you're resting.), fracture of unspecified parts of lumbosacral spine and pelvis (a medical condition that can be cause by trauma or disease), and subsequent encounter for a fracture with routine healing (a type of care that occurs during the healing or recovery phase of a fracture).</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected a Brief Interview for Mental Status score of 13, indicating her cognition was intact. MDS's Section I - Active Diagnoses reflected Resident #1 had venous insufficiency, chronic, peripheral (improper functioning of the vein valves in the les, causing swelling and skin changes), and atherosclerosis of native arteries of extremities with right pain to the right leg (a condition that occurs when arteries in the legs and feet narrow and harden due to plaque buildup, which can cause pain, numbness, and cold extremities.). The MDS Section GG Functional Abilities indicated Resident #1 was dependent on staff for rolling left and right, lying to sitting on the side of her bed, transferring from chair/bed-to-chair, and was unable to walk 10 feet due to medical condition or safety concerns.</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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's Care Plan dated 09/05/2024 included pain, which was added on 10/22/24, due to acute pain, chronic pain, and neuropathic pain. The goal was that these pains would be resolved or be within a tolerable range within one hour of intervention over the next 90 days. The approach, which would be administered by nursing, included administering pain medications as ordered, establish causative factors and way to alleviate them, monitor pain, and position for comfort. This plan included Resident #1's activities of daily living with start date of 10/22/24 and the goal was to anticipate and meet her needs with 1-2 person assist for ambulation and transfers.</p> <p>Review of Resident #1's Physician Order Report dated 09/30/2024 to 10/31/24 reflected: Hydrocodone-Acetaminophen - Schedule II table; 5-325 mg; amount: one tablet; oral every 4 hours - PRN; PRN 1, PRN 2, PRN 3, PRN 4, PRN 5, and PRN 6.</p> <p>Review of an e-mail dated 10/30/24 at 9:17 A.M. indicated Assistant Director of Nursing (ADON C) sent an e-mail on 10/30/24 at 10:09 A.M. to Pharmacy Technician (PT D) indicating the lock box with the residents' narcotics was not opening with the key, and this box was in the medication cart on Station 1.</p> <p>Review of e-mail attachment dated 11/01/24 and written by P H indicated a medication dose for Resident #1 was not requested from the facility's Stat Safe (EKit) on 10/30/24 between 5 A.M. and 2 P.M.</p> <p>Review of Resident #1's Medication Administration Record dated 10/01/24 - 10/31/24 PRN 1 for Hydrocodone - Acetaminophen - Schedule II table; 5-325; amount to administer: one tablet oral, indicated on 10/30/24 at 5:35 A.M. her pain level was a 6 and at 2:04 P.M. her pain level was a 4. This report reflected these medications were not given to Resident #1.</p> <p>During an interview on 10/30/24 at 12:05 P.M. with Resident #1 she asked Licensed Vocational Nurse (LVN A) for her Hydrocodone pill on 10/30/24 at approximately 4:30 A.M. LVN A returned and said she could not open the lock box with the narcotics. Resident #1 said she did not ask her for a different pain pill. Resident #1 said at approximately 7:30 A.M. Certified Medication Aide (CMA B) administered her medications, and that was when she asked her for her Hydrocodone; however, CMA B said she could not give it to her. Resident #1 said she did not ask for a different pain pill. Resident #1 said CMA B administered her medications at approximately 12 P.M., and that's when she asked her for her Hydrocodone. CMA B said she could not administer her pill because the box was locked, and Resident #1 did not ask her for a different pain pill. Resident #1 said she thought it was about 6 P.M. when she received her Hydrocodone.</p> <p>During an interview on 10/31/24 at 12:47 P.M. with LVN A indicated on 10/30/24 at approximately 6 A.M., Resident #1 asked her for her Hydrocodone for pain, which was PRN, and she can take every 4 hours as needed. LVN A said she could not open the locked box with Resident #1's Hydrocodone, and informed LVN F that she could not administer Resident #1 her Hydrocodone. LVN F said she would take care of it (locked box). LVN A said the facility has an EKit; however, it does not include Hydrocodone because it required a triplicate order. LVN A said Resident #1 had Tylenol; however, she did not give it to her because she asked for Hydrocodone. LVN A said she should have notified the nurse practitioner or used the EKit to administer Resident #1's Hydrocodone.</p> <p>During an interview on 10/30/24 at 2:20 P.M. with DON E indicated the physician would have to call in an order for one narcotic pill; however, she was not sure if the physician was notified.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/30/24 at 2:59 P.M. with Certified Medication Aide (CMA B) indicated at approximately 7 A.M. she was informed the box with the narcotics could not be unlocked because the key was not working. CMA B said at approximately 7:30 P.M. Resident #1 asked for her Hydrocodone, and she informed her that she could not give her this pill because the box could not be unlocked. CMA B said she did not report to LVN F that Resident #1 requested her Hydrocodone. CMA B said after this medication pass, she informed the Director of Nurses (DON E) that she could not give Resident #1 her Hydrocodone. DON E informed her that they were sending someone to repair the box. CMA B said she did not inform LVN B that resident was in pain and wanted her Hydrocodone.</p> <p>During an interview on 10/30/24 at 3:27 P.M. with LVN G indicated she was informed by LVN A that she had not been able to open the narcotics box since 5:30 A.M. LVN G said LVN A tried to administer Resident #1 her Hydrocodone but could not unlock the box with the narcotics. LVN G said Resident #1 had a history of asking for her Hydrocodone as if they were scheduled. LVN G said she was not informed by CMA B that Resident #1 had asked for her Hydrocodone on 10/30/24 at 7:30 A.M. and at 12 P.M. LVN G said the process would have been to notify the charge nurse, assess her pain level, administer the pill ordered, if out of this pill give the resident a substitute, like Tylenol, and call the physician. LVN G said she did not attempt to obtain this pill from the Stat Safe (EKit with medications to use in an emergency), because when she checked on Resident #1, she was asleep. LVN G said to use the EKit you must call the pharmacy for a code to obtain the Hydrocodone.</p> <p>During an interview on 10/01/24 at 8:30 A.M. with P H indicated Resident #1 had Hydrocodone in the Stat Safe (EKit) that was in the facility's medication room. When Resident #1's Hydrocodone was delivered to the facility she was sent 29 of 30 days, and the 30th day was her backup for when she runs out or there was an emergency requiring access to her Hydrocodone. The nurse needed to input the resident's information and the medication needed into the EKit, and the EKit would indicate if the medication was available. If it was, the facility's nurse should call the pharmacy to obtain a code that they input into the EKit, which dispensed the pill.</p> <p>Observation on 11/01/24 at approximately 3 P.M., DON E demonstrated how the EKit worked by inputting Resident #1's information and the medication needed. The EKit's digital response indicated Resident #1 had Hydrocodone available in the E-Kit. Prior to this demonstration, DON E was not aware the EKit had Hydrocodone that could be dispensed by calling the pharmacist for the code.</p> <p>Record review of the facility's policy and procedure Preparation and General Guidelines dated 06/01/22 indicated medications are administered as prescribed in accordance with good nursing principles and only by legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without interruptions.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy and procedure for Medication Ordering and Receiving from Pharmacy dated 06/01/22 indicated Emergency pharmacy services are available on a 24-hour basis. Emergency needs for medications are met by the facility's approved emergency medication supply or by special order from the provider pharmacy. The pharmacy supplies emergency medications including emergency drugs, antibiotics., (controlled substances, products for infusion) and routine medications where appropriate, in limited quantities (in portable, sealed containers, automated dispensing units ([NAME])) in compliance with applicable state regulations. To access medication from the emergency kit or ADS, secondary to a new order or when medication for which there is a current prescription is not readily available, the nurse should not take a medication from the e-box or ADS without checking allergies on the medical record and possible drug-drug interactions with pharmacist. The nurse confers with the prescriber to determine whether the order is a true emergency order and cannot be delayed until the scheduled pharmacy delivery. The nurse may alert, if the medication is a controlled substance, the prescriber either faxes a complete prescription to the facility and pharmacy or communicates the verbal order to both the nurse and directly to the pharmacist along with details about the situation to [NAME] that it meets the criteria of an emergency situation. Only after verifying the above has occurred, the pharmacy has received a complete prescription, the nurse unlocks the container/cabinet/breaks the container's seal or accesses the ADU via assigned security codes and removes the required medication. If the medication is not available in the emergency kit, the nurse contacts the pharmacy, using the after-hours emergency number if necessary.</p>		