

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Haskell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 North First St Haskell, TX 79521	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305</p> <p>Based on interview and record review, the facility failed to ensure that drugs and biologicals used in the facility were secured properly for 1 of 5 (Resident #1) residents in that:</p> <p>1. LVN A failed to ensure medications for Resident #1 were secure when she left Resident #1's medications in a cup on the bedside table and walked out of the room.</p> <p>This failure could place residents at risk for harm and result in drug diversion due to medications not being properly secured.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Atherosclerotic Heart Disease (buildup of plaque in the arteries), Paroxysmal Atrial Fibrillation (rapid, irregular heartbeat that lasts a few hours or days), Hypertension (high blood pressure), Anxiety, Gastro-Esophageal Reflux Disease (digestive condition in which the stomach contents move up into the esophagus), Altered Mental Status (change in mental function), and Age-Related Cognitive Decline (difficulty with thinking, memory and concentration).</p> <p>Record review of Resident #1's annual MDS dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive impairment.</p> <p>Record review of Resident #1's current Physician's orders revealed the following orders: Buspirone tablet; 10 mg; amt: 1 oral. Three times a day 08:00 AM, 12:00 PM, 07:00 AM with a start date 09/17/24. Colace (docusate sodium) [OTC] capsule; 100 mg; amt: 1; oral. Once a day 08:00 AM with a start date of 02/26/24. Diltiazem HCl capsule, extended release; 240 mg; amt: 1 cap; oral; once a day 08:00 AM with a start date of 11/08/24. Lisinopril tablet; 10 mg; amt: 1; oral. Once a day 08:00 AM with a start date of 10/09/24. Omeprazole capsule, delayed release; 20 mg; amt: 1; oral. Once a day 08:00 AM with a start date of 08:00 AM. Prednisone tablet; 5 mg; amt: 1; oral. Once a day 08:00 AM with a start date of 10/09/24. Xarelto (rivaroxaban) tablet; 20 mg; amt: 1 tab; oral. Once a day 08:00 AM.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Haskell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 North First St Haskell, TX 79521	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's MAR dated 01/21/25 revealed the resident received medications on 01/18/25, according to Physician's orders to include the following: Buspirone tablet; 10 mg; amt: 1 oral. Three times a day 08:00 AM, 12:00 PM, 07:00 AM with a start date 09/17/24. Colace (docusate sodium) [OTC] capsule; 100 mg; amt: 1; oral. Once a day 08:00 AM with a start date of 02/26/24. Diltiazem HCl capsule, extended release; 240 mg; amt: 1 cap; oral; once a day 08:00 AM with a start date of 11/08/24. Lisinopril tablet; 10 mg; amt: 1; oral. Once a day 08:00 AM with a start date of 10/09/24. Omeprazole capsule, delayed release; 20 mg; amt: 1; oral. Once a day 08:00 AM with a start date of 08:00 AM. Prednisone tablet; 5 mg; amt: 1; oral. Once a day 08:00 AM with a start date of 10/09/24. Xarelto (rivaroxaban) tablet; 20 mg; amt: 1 tab; oral. Once a day 08:00 AM.</p> <p>During a phone interview on 01/21/25 at 4:47 PM, LVN A stated she worked weekends at the facility. She stated she was at work on 01/18/25 and was scheduled to work from 06:00 AM to 06:00 PM that day. LVN A stated she was passing medications on hall 3 between approximately 07:30 AM and 08:30 AM and she parked the medication cart outside Resident #1's room. She stated she dispensed Resident #1's morning medications into a medication cup and took the medications in to Resident #1. She stated Resident #1 did not like to be rushed and preferred to take her medications one at a time while she visited with staff. LVN A stated, while in Resident #1's room, another resident across the hall called for assistance. She stated Resident #1 had not taken any of her medications yet and she left the cup of medications on Resident #1's bedside table, left the door open and walked across the hall to check on the resident who called for assistance. LVN A stated she thought she would be gone from Resident #1's room briefly but the interaction with the other resident took longer than she expected. She stated she was gone from Resident #1's room for approximately five to ten minutes. She stated she re-entered Resident #1's room and observed Resident #1 holding the cup of medications. She stated she observed Resident#1 take each medication in the cup one-by-one. She stated she then made sure the resident was comfortable and exited the room. LVN A stated she should not have left the cup of medications unattended in the room, even briefly. She stated she should have taken the cup of medications with her and locked them in the medication cart when she left the room to check on another resident.</p> <p>During a follow-up phone interview on 01/21/25 at 05:14 PM, LVN A stated she had been trained to witness a resident take all dispensed medications prior to leaving the room and signing the MAR. LVN A stated she had been trained on proper medication storage and administration through quarterly in services and through medication pass observations conducted by the ADON. She stated a potential negative outcome for leaving medications unsupervised and unsecured would be that the resident may drop a medication, which would result in not receiving medications as ordered by the physician.</p> <p>During an interview on 01/21/25 at 05:47 PM, the DON stated he was not aware that medications had been left unsupervised by LVN A on 01/18/25. He stated LVN A should not have left medications unsupervised in a resident room. He stated she should have put the medications back in the cart and locked the cart. He stated all staff had been trained not to leave a resident unattended with medications. The DON stated staff were trained on proper medication storage and administration through annual skills checks and quarterly medication administration observations conducted by the pharmacy consultant. He stated a potential negative outcome for failure to properly secure medications would be the resident could miss a dose or another resident could take medication that was not ordered for them.</p> <p>Record review of a facility training document titled Licensed Nurse Proficiency Audit, dated 05/03/24, revealed LVN A's name and satisfactory was checked for the skill administers medication properly.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Haskell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 North First St Haskell, TX 79521	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility-provided policy titled Medication Administration - Orals, dated 2007 revealed:</p> <p>Policy</p> <p>To administer oral medications in an organized, accurate and safe manner.</p> <p>Procedures</p> <p>.</p> <p>10. administer medication and remain with resident while medication is swallowed. Do not leave a medication in a resident's room without orders to do so along with documentation of self-administration.</p>