STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675017	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Country Healthcare Center	1514 Indian Creek Rd Brownwood, TX 76801

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 - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31886 Based on observation, interview, and record review the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained for 1 of 1 medication rooms reviewed for medication labeling and storage. The facility failed to maintain controlled substance record count sheet with accurate amount of lorazepam (a controlled substance) stored in medication room refrigerator. These failures could place residents at risk of misappropriation of medications. Findings Included: Record review of Resident #3's electronic face sheet dated 01/23/2025 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and most recently on 01/13/2025 with diagnoses to include: conversion disorder with seizures or convulsions (a mental health condition that causes seizures or convulsions) and anxiety. Record review of Resident #3's quarterly MDS dated [DATE] revealed: BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS Section I - Active Diagnoses revealed resident had seizure disorder or epilepsy and anxiety disorder. Record review of Resident #3's care plan dated 01/23/2025 revealed Resident #3 had seizures. Further review of care plan revealed interventions for seizures included to give medications as ordered, monitor/document effectiveness and side effects, use half side rails with seizure pads added to resident bed for safety, and to document seizure activity. Record review of Resident #3's electronic physician orders dated 01/21/2025 revealed one time order for Ativan (lorazepam) 2mg/ml inject 2mg IM (intramuscularly) one time only for anxiety. Further review revealed an electronic physician order dated 01/14/2025 lorazepam injection 1mg IM every 5 minutes prn anxiety. Record review of Resident #3's nursing progress notes which indicated that resident received 4 doses of Ativan (lorazepam) IM on 1/21/2025. Further review of nursing progress notes indicated Resident #3 received 1 dose of Ativan (lorazepam) IM on 1/22/2025 at 5:08 p.m. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
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(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 - Few	Record review of Resident #3's narcotic count sheet titled controlled substance record indicated 4 doses of lorazepam were administered on 1/21/2025. There was no evidence that 1 dose of lorazepam had been administered on 1/22/2025. During an observation and interview on 01/23/2025 at 11:48 a.m., the medication room refrigerator had a sealed bag of lorazepam vials for Resident #3 inside of the controlled substance box that had 25 vials inside of the box. LVN A was present and agreed that there were 25 vials of lorazepam in sealed bag for Resident #3. LVN A stated medications were counted every shift to make sure that the counts were correct. She stated she had not counted the medication in the refrigerator because she was not responsible for 200-300 medication cart which had the count sheets for Ativan (lorazepam) in the binder. During an interview on 01/22/2025 at 12:10 p.m., MA C stated she was responsible for the 200-300 hall medication cart. She observed the controlled substance count sheet and agreed that it stated 26 vials of lorazepam should be in the refrigerator for Resident #3. She stated she should have counted the refrigerator medications when she took control of the 200-300 medication cart at shift change. She stated she did not count the refrigerator medications this morning during shift change. She did not answer why she did not count the medications in the refrigerator when asked. During an interview on 01/23/2025 at 12:14 p.m., the DON stated medication aides and nurses were responsible for making sure controlled substance count sheets were accurate with medication on hand during shift change. He stated that both he and the ADON monitored the medication aides and nurses performed counts and had just counted the medication room fridge on 01/22/2025 before 4:00 p.m. and the count was correct. He stated he expected for nurses and medication aides to sign out medication on the controlled substance count sheets as they were given. He stated medication aides and nurses were to contact him if the count did not match what was written on the controlled substance count sheet and he would do an investigation to see why count sheets were off. He stated he would let corporate and state agency know of issue when his investigation could not find reason for why counts sheets were incorrect. He stated he would investigate why Ativan (lorazepam) did not match controlled count sheet. During a follow up interview on 01/23/2025 at 1:00 p.m., the DON stated his investigation led to the finding that LVN B had given lorazepam on 01/22/2025 around 5:00 p.m. He stated had LVN B signed the medication off of the controlled substance count sheet, the counts would match how much medication was on hand in the refrigerator. He stated the nurses and medication aides had been educated in the past about making sure count sheets were accurate and counted every shift change. He stated he felt more education was needed. During an interview on 01/23/2025 at 1:02 p.m., LVN B stated Resident #3 was having a seizure on 01/22/2025 around 5:00 p.m. and his hospice nurse was present in the facility. She stated she remembered the time because a new admission had arrived at the facility around the same time. She stated she had gotten medication vial from refrigerator in the medication room and had administered the Ativan (lorazepam) to Resident #3. She stated she did not sign it out on the controlled substance count sheet because she was distracted. She stated it was important to sign out medication use on controlled substance count sheet to keep account of the medication and prevent someone from taking it. (continued on next page)

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(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 - Few	During an observation on 01/23/2025 at 2:38 p.m., Resident #3 was in his room lying in bed that was in low position. He had side rails that were padded on his bed. His eyes were closed and no distress observed. His respirations were even and unlabored. Resident #3's call light was within reach of him. During an observation and interview on 01/24/2025 at 5:50 p.m., LVN D counted controlled substances in medication room refrigerator with MA C. LVN D removed keys from beside of the refrigerator and opened the locked box inside of the refrigerator to count the medications. She stated whoever was responsible for 200-300 medication cart should count the controlled substances in the refrigerator. She stated she had not been responsible for 200-300 medication cart on 1/22/2025 and was unsure why the controlled substances were not correct on the count sheet on 01/23/2025. During an interview on 01/24/2025 at 6:04 p.m., RN E stated she was responsible for 200-300 medication cart on the night of 01/22/2025. She stated she should have counted the controlled substances in the medication room refrigerator. She stated she had been education in the past to count the box for controlled substances in the refrigerator when she was responsible for the 200-300 medication cart. She did not give a reason why she did not count the controlled substances the night of 01/22/2025. She stated controlled substances were counted to prevent loss of medication from people taking medication out of the controlled substance box. During a telephone interview on 01/24/2025 at 8:41 a.m., the MD stated he expected for controlled medications to be counted every shift and for staff to follow facility's policy. He stated he expected for nurses and medication aides to follow facility policy when storing controlled substances. He stated the DON was responsible for monitoring that nurses and medication aides followed the policy. The MD stated he does not review the narcotic count sheets during his resident review of how often medication was administered. He stated he obtains medication administration frequency from the DON and does not know where the DON obtains that information. During an interview on 01/24/2025 at 10:30 a.m., the ADON stated the facility utilized controlled substance count sheets to correctly manage the controlled substances and dosages. She stated the controlled substance count sheets do help keep track of medication and reduce risk for misappropriation. She stated her expectation would be that the controlled substance count sheets be promptly updated when a medication dose had been given. She stated both her and the DON do weekly audits to make sure the controlled substances matched what was documented on the controlled substance count sheets. During a telephone interview on 01/24/2025 at 11:44 a.m., the pharmacy consultant stated she rounded in the facility once a month. She stated she would do random spot checks of controlled substance count sheets to see if nurses and medication aides were signing medication in and out. She stated her expectation would be that the medication on hand match the controlled substance count sheet. She stated the negative effect of controlled substances not being accurate could be misappropriation of medications. She stated nurses and medication aides should document medication on controlled substance count sheet as soon as the medication was given. During a follow up interview on 01/24/2025 at 10:54 a.m., the DON stated staff laziness may have led to the failure of staff not counting the controlled substances in refrigerator because they had been educated to do so prior to 01/22/2025. He stated not counting controlled substance during shift change could lead to misappropriation of medications and if not found then licensure reporting to appropriate agency. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/24/2025 at 1:09 p.m., the ADMN stated she expected for controlled substance count sheets to accurately reflect the amount of medication in storage. She stated controlled substance count sheets were done to help prevent medication misappropriation. She stated she expected for staff to go by facility policy when storing medications. She stated the ADON and the DON monitored that staff were controlled substances during shift change. Review of drugs.com accessed on 01/24/2025 at https://www.drugs.com/schedule-4-drugs.html revealed: Ativan (lorazepam) was listed under The following drugs are listed as Schedule 4 (IV) Drugs by the Controlled Substances Act (CSA) Review of the facility policy titled Controlled Substances dated July 2024 revealed: Dispensing and Reconciling Controlled Substances 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection / follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services .15. The consultant pharmacist or designee routinely monitors controlled substance storage records. 16. The director of nursing services maintains and disseminates to appropriate individuals a list of staff who have access to medication storage areas and controlled substance containers.

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(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. 31886 Based on observation, interview, and record review the facility failed to ensure separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse for 1 of 1 medication rooms reviewed for medication labeling and storage. The facility failed to maintain controlled substance record count sheet with accurate amount of lorazepam (a controlled substance) stored in medication room refrigerator. These failures could place residents at risk of misappropriation of medications. Findings Included: During an observation on 01/23/2025 at 11:48 a.m., the medication room refrigerator had a locked box inside of the refrigerator that was not secured and could be removed easily from the refrigerator. Keys to the locked box, inside of the refrigerator, were stored on a hook that was secured to the left of the outside of the refrigerator. Anyone with access to the medication room had access to the locked box key. During an observation and interview on 01/24/2025 at 5:50 p.m., LVN D counted controlled substances in medication room refrigerator with MA C. LVN D removed keys from beside of the refrigerator and opened the locked box inside of the refrigerator to count the medications. During a telephone interview on 01/24/2025 at 8:41 a.m., the MD stated he expected for nurses and medication aides to follow facility policy when storing controlled substances. He stated the DON was responsible for monitoring that nurses and medication aides followed the policy. During an interview on 01/24/2025 at 10:30 a.m., the ADON stated the locked box in refrigerator, for controlled substances, should be secured to the refrigerator. She stated she did not know why the box had not been secured to the refrigerator. She stated the keys to the locked box in refrigerator for controlled substances should not be kept to the left outside of the refrigerator and should be stored on the nurse or medication aide keys that were responsible for the medication cart that kept the controlled substance count sheets in binder. She stated she did not know why keys had been stored next to the refrigerator but that storing the key that way could cause potential misuse of the controlled medications. She stated both her and the DON monitor that medication were stored appropriately. During a telephone interview on 01/24/2025 at 11:44 a.m., the pharmacy consultant stated she expected for staff not to store key to the locked box in the medication room next to the unlocked refrigerator. She stated the facility had moved the medication room recently from the back of the facility to the front and that may have led to controlled substances to not be stored appropriately. She stated the controlled substance box should be secured to the refrigerator and did not know why it was not. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 01/24/2025 at 10:54 a.m., the DON stated the controlled substance box should be secured to the refrigerator and the keys to the box should not be stored outside of the refrigerator for all staff that had access to the medication room to have access to the controlled substances in the locked box. He stated recently the controlled substance box had been replaced due to the old one had rusted and he felt that led to the failure of new controlled substance box not being affixed. He stated staff laziness may have led to the failure of the key to the controlled substance box being stored next to the refrigerator in medication room. He stated not storing medication correctly could lead to misappropriation of medications During an interview on 01/24/2025 at 1:09 p.m., the ADMN stated she expected for staff to go by facility policy when storing medications. She stated the ADON and the DON monitored that staff were storing medications appropriately. Review of the facility policy titled Controlled Substances dated July 2024 revealed: Storing Controlled Substances. 1. 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. 2. All keys to controlled substance containers are on a single key ring that is different from any other keys. 3. The charge nurse on duty maintains the keys to controlled substance containers. The director of nursing services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31886 Based on interview, and record review the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, that were complete and accurate for 1 (Resident #3) of 6 residents reviewed for resident records. The facility failed to ensure Medication Administration Records were accurate in the electronic medical record for Resident #3. This failure could place residents at risk of having errors in care and treatment. The Findings included: Record review of Resident #3's electronic face sheet dated 01/23/2025 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and most recently on 01/13/2025 with diagnoses to include: conversion disorder with seizures or convulsions (a mental health condition that causes seizures or convulsions) and anxiety. Record review of Resident #3's quarterly MDS dated [DATE] revealed: BIMS score of 03 which indicated severe cognitive impairment. Further review of the MDS Section I - Active Diagnoses revealed resident had seizure disorder or epilepsy and anxiety disorder. Record review of Resident #3's care plan dated 01/23/2025 revealed Resident #3 had seizures. Further review of care plan revealed interventions for seizures included to give medications as ordered, monitor/document effectiveness and side effects, use half side rails with seizure pads added to resident bed for safety, and to document seizure activity. Record review of Resident #3's electronic physician orders dated 01/21/2025 revealed one time order for Ativan (lorazepam) 2mg/ml inject 2mg IM (intramuscularly) one time only for anxiety. Further review revealed an electronic physician order dated 01/14/2025 lorazepam injection 1mg IM every 5 minutes prn anxiety. Record review of Resident #3's nursing progress notes which indicated that resident received 4 doses of Ativan (lorazepam) IM on 1/21/2025. Further review of nursing progress notes indicated Resident #3 received 1 dose of Ativan (lorazepam) IM on 1/22/2025 at 5:08 p.m. Record review of Resident #3's MAR dated January 2025 revealed no evidence that Ativan (lorazepam) had been administered on 1/22/2025. (continued on next page)

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 01/23/2025 at 1:02 p.m., LVN B stated she had administered lorazepam IM to Resident #3 on 01/22/2025. She stated she had written a progress note about resident on that date but must have forgotten to document medication administration on the MAR. She stated Resident #3's hospice nurse was present when lorazepam IM was administered, and medication was for an active seizure that Resident #3 had. She stated she felt being distracted prevented her from documenting medication administration in the MAR. She stated she knew to document medication administration in the resident's medical record and not performing could cause other nurses not to know she had administered the medication.

During a telephone interview on 01/24/2025 at 8:41 a.m., the MD stated he expected for medication administration records to be correct for residents. He stated he expected for nursing staff to follow the facility's policy on medication administration and for the ADON and DON to monitor that nursing staff was following that policy. He stated he did not review MARs for his knowledge of the residents in the facility and would get information that he needed from the DON.

During an interview on 01/24/2025 at 9:30 a.m., the ADMN stated the facility should follow the medication administration policy for clinical documentation of medications being administered. She stated the facility did not have a clinical documentation policy and used the medication administration policy.

During an interview on 01/24/2025 at 10:30 a.m., the ADON stated she expected for nurses and medication aides to document medication administration on the MARs to help prevent medication errors. She stated documentation should be completed when medication was administered and no later than the end of nurses' and medication aide's shift. She stated the resident's clinical record should reflect what was going on with the residents including the medications that residents had taken to help prevent adverse effects. She stated both herself and the DON monitored that nurses and medication aides documented medications in the medical record. She stated emergent situation may have caused the nurse to forget to document the medication administration.

During an interview on 01/24/2025 at 10:54 a.m., the DON stated he expected for the resident's MARs to reflect what medication had been given to those residents. He stated it was the responsibility of the nurse or medication aide to document medication administered on the MAR. He stated both he and the ADON monitored weekly that nurses and medication aides were documenting correctly by random chart reviews. He stated not documenting medications on the MAR would not affect what he reported to the MD because he used the controlled substance count sheets to see how frequently controlled substances were given. The DON stated it was easier to identify the time and frequency of medication administration on the controlled substance count sheets opposed to the MARs. He stated when Ativan (lorazepam) medication was documented on the MAR, it would trigger for the nurse to document the effectiveness of the medication. He stated not documenting Ativan (lorazepam) administration on the MAR could interfere with monitoring the effectiveness of medication.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 01/24/2025 at 12:17 p.m., the pharmacy consultant stated she rounded in the facility once a month. She stated she did look at resident's MARs but did not monitor the MARs when in the building. She stated she relied on physician orders to see what medications were prescribed for her medication reviews. She stated she made recommendations based on physician orders. She stated she would expect for the MAR to reflect what medication had been given to residents. She stated not documenting on the MAR could interfere with other nurses and medication aides knowing what had been given to monitor the effectiveness of the medication. She stated not documented could also interfere with nurses to know to monitor for side effects including lethargy (difficult to be aroused / sleepy). During an interview on 01/24/2025 at 1:09 p.m., the ADMN stated she expected for nursing staff to follow policy when documenting medication administration. She stated the ADON and DON monitored that nursing staff followed the policy. She stated she expected for documentation to be completed by the end of the nurses' or medication aides' shift. She stated the MAR should reflect what had been given to the resident. She stated not documenting medication administration could cause adverse reaction to occur or could delay the responses to effectiveness of the medications. Review of facility policy titled Medication Administration dated 07/08/2024 revealed: 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. 2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions .22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage; c. the route of administration; d. the injection site (if applicable); e. any complaints or symptoms for which the drug was administered; f. any results achieved and when those results were observed; and g. the signature and title of the person administering the drug.