STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675035	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Healthcare Center	406 E Seventh St Burkburnett, TX 76354

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50133 Based on observation, interview, and record review, the facility failed to ensure a medication error rate are not greater than 5 percent. There were 2 errors out of 25 opportunities which resulted in an 8 percent error rate involving Resident #8. 1.LVN A failed to follow physician's order when she flushed Resident #8's PICC line with Heparin flush (blood thinner) 5 ml of 10u/ml. 2.LVN A failed to administer Meropenem ordered by physician for Resident #8 within time frame ordered. These failures could place residents at risk of medication side effects from not receiving their medications as prescribed according to physician's orders and manufacturers recommendations. The finding included: Review of Resident #8's face sheet dated 12/12/24 reflected a [AGE] year-old female male admitted to the facility on [DATE] with most recurrent readmission on 10/19/24 with the following diagnoses: Osteomyelitis (bone infection) right great toe, atrial fibrillation (irregular heart rate). Record review of Resident #8's order listing report dated 12/12/2024 indicated: oOrdered 11/22/2024 Meropenem reconstitute solution; 500 mg; intravenous; Three Times A Day at 6:00am, 12:00pm and 6:00pm. oOrdered 11/22/2024 Flush Central Line Lumen with 10ml of Normal Saline before and after each administration of IV medication or fluids. Every Shift oOrdered 11/22/2024 Flush each Lumen of Central Line with 10ml of Normal Saline every 8 Hours. There was no physician order for Heparin flush for Resident #8. Observation on 12/10/24 at 12:03 PM revealed LVN A entered Resident #8's room to disconnect IV antibiotic (Meropenem). Upon disconnecting IV from PICC, LVN A administered normal saline flush 10ml then administered Heparin flush 6ml via PICC line to right arm. (continued on next page)

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/11/24 at 1:31 PM revealed LVN A administered Meropenem 500mg IV via PICC. Medication Reconciliation review on 12/11/24 revealed 25 opportunities with 2 medication errors. This resulted in an 8 percent medication error rate. In an interview on 12/10/24 at 12:06 PM LVN A stated, I just gave saline flush 10 cc and then cleaned it and gave Heparin flush 6 ml, which is what was in the syringe. She further stated that she had already clicked it off on the screen and was unable to show surveyor order on her screen. In an interview on 12/11/2024 at 1:58pm LVN A stated Meropenem ordered to be started at 12:00p was not started until 1:31pm. LVN A stated that medication was given late due to being busy and she was waiting on Resident #8 to finish lunch. LVNA stated Our normal protocol is SASH method (saline, antibiotic, saline and heparin flush). She further stated that she didn't recall the physician order for heparin flush that was given to Resident #8 the previous day. She stated the expectation for medication administration is to review the MAR and medications before giving. She stated that administering a medication to a resident without a physician's order could cause an adverse reaction, specifically, in this case, redness or bleeding from PICC line. Observation on 12/11/24 at 4:09 PM of medication cart on east hall revealed Heparin flush Lock Flush solution 50 units/5ml with each syringe having 6ml in syringe. There was no pharmacy label on the Heparin flush that included a resident name or directions. In an interview on 12/11/24 at 4:16 PM with the Medical Director regarding heparin flush being used in SASH method after PICC IV antibiotic infusion for Resident #8, he stated I did not order that. I was not aware. He stated that administration of heparin flush in PICC is always a risk of bleeding. He stated his expectation is that a nurse should not administer anything without an order and doing so could cause harm. In an interview on 12/11/24 at 4:44 PM with RNC she stated that her expectation for medication I expect them (facility staff) to check the physician orders, make sure nothing has changed, I expect orders to be checked and followed. I expect for them to be given within the time frame unless the resident is requesting different. She further stated, I probably don't have a specific administration thru a PICC line policy, they should the generalized IV medication administration policy. She stated that there are no standing orders for PICC lines, nor is the SASH method (saline, antibiotic, saline and heparin flush) facility protocol. She further stated that her expectation is not to administer a medication like heparin flush without an order. She further stated that she expects the physician to be contacted. She stated an Adverse outcome of Resident receiving heparin flush without order the resident could have issues with her blood clotting. She stated that she was not aware that heparin flush was administered. She verified that the heparin flush prefilled syringe on the medication cart had 6ml per syringe after opening a flush from the bag and viewing in front of surveyor. Record review of LVN A personnel file revealed Validation Checklist for Flushing and Locking Central Venous Access/Midline/PICC Catheter dated 9/12/24 revealed that nurse was satisfactory in procedure observed and included Reviewed care plan and orders and Lock CVAD 's with either preservative-free 0.9% sodium chloride or heparin flush 10units/ml (or according to manufacturer's directions). Record Review of facility policy Specific Medication Administration Procedures dated 6/1/22 revealed the following [in-part]: (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: To administer medications in a safe and effective manner. Procedures: C. Review 5 Rights (3) times: 1.Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order. b. Note any allergies or contraindications the resident may have prior to drug administration. C .If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. d. Check for vital signs, other tests to be done during/prior to medication administration. e. Prepare resident for medication administration. 2.Prior to removing the medication from the container a. Check the label against the order on the MAR. Review of National Library of Medicine, https://www.ncbi.nlm.nih.gov/books/NBK560654/ , dated 09/04/23 titled Nursing Rights of Medication Administration revealed the following [in-part]: The five traditional rights in the traditional sequence include: 1.Right patient - ascertaining that a patient being treated is, in fact, the correct recipient for whom medication was prescribed. 2.Right drug - ensuring that the medication to be administered is identical to the drug name that was prescribed. 3.Right Route - Medications can be given to patients in many different ways, all of which vary in the time it takes to absorb the chemical, time it takes for the drug to act, and potential side-effects based on the mode of administration. Some common routes include oral, intramuscular, intravenous, topical, or subcutaneous injection. 4.Right time - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms. 5.Right dose - Incorrect dosage, conversion of units, and incorrect substance concentration are prevalent modalities of medication administration error. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Drugs.com accessed on 12/18/24 at Heparin flush Uses, Side Effects & Warnings revealed in part: Heparin flush is used to flush (clean out) an intravenous (IV) catheter, which helps prevent blockage in the tube after you have received an IV infusion Heparin flush is injected directly into the catheter lock of your IV (intravenous) line. You may be shown how to use heparin flush at home. Do not use heparin flush if you do not fully understand how to flush your IV line and properly dispose of used needles, IV tubing, and other items used to inject your medicines. Follow your doctor's instructions. Record review of Drugs.com access on 12/18/24 at https://www.drugs.com/mtm/meropenem.html revealed in part: Meropenem is an antibiotic that is used to treat bacterial infections of the skin and stomach in adults and children at least 3 months old . Meropenem may also be used for purposes not listed in this medication guide . Follow all directions on your prescription label and read all medication guides or instruction sheets. Use the medicine exactly as directed . Prepare an injection only when you are ready to give it . Skipping doses could make your infection resistant to medication . Avoid missing doses and complete the entire course of therapy. Record review of the National Library of Medicine, accessed on 12/23/24 at https://pubmed.ncbi.nlm.nih.gov/7648757/#:~:text=Plasma%20meropenem%20concentrations%20reach%20a%20peak%20%28Cmax%29%20of,concentration-time%20curve%20increases%20linearly%20in%20a%20dose-related%20manner revealed in part: Plasma meropenem concentrations reach a peak (Cmax) of approximately 30 mg/L after administration of a standard dose of 1 g intravenously. The elimination half-life (t1/2) is approximately 1 hour

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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 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** 50133 Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 10 residents reviewed for medication administration. (Resident #8). LVN A failed to follow physicians orders when she flushed Resident #8's PICC line with Heparin flush (blood thinner) 6 ml of 10u/ml. This failure could place residents Resident #8 at risk of their health and safety being jeopardized. Findings included: Record review of Resident #8's admission record dated 12/11/2024 indicated she was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a diagnosis of Other acute osteomyelitis (bone infection), other site - Right Great Toe. Record review of Resident #8's physician's order report dated 12/11/2024 indicated that she was not prescribed Heparin flush 50units/5ml via PICC. Record review of Resident #8's care plan dated, 11/22/204 indicated [in part]: Problem: Infection Alert - Osteomyelitis of Right Great Toe. Goal: Resolve infection. Interventions: Infection control per protocol. Meds as ordered. Monitor for S/S of infection. Monitor wound/lesion status and progress. VS every shift. Observation on 12/10/24 at 12:03 PM revealed LVN A entered Resident #8's room to disconnect IV antibiotic (Meropenem). Upon disconnecting IV from PICC, LVN A administered normal saline flush 10ml then administered Heparin flush 6ml via PICC line to right arm. In an interview on 12/10/24 at 12:06 PM LVN A stated, I just gave saline flush 10 cc and then cleaned it and gave Heparin flush 6 ml, which is what was in the syringe. She further stated that she had already clicked it off on the screen and was unable to show surveyor order on her screen. In an interview on 12/11/24 at 1:58 PM LVNA stated Our normal protocol is SASH method (saline, antibiotic, saline and heparin flush). She further stated that she didn't recall the physician order for heparin flush that was given to Resident #8 the previous day. She stated the expectation for medication administration is to review the MAR and medications before giving. She stated that administering a medication to a resident without a physician's order could cause an adverse reaction, specifically, in this case, redness or bleeding from PICC line. Observation on 12/11/24 at 4:09 PM of medication cart on east hall revealed Heparin flush Lock Flush solution 50 units/5ml with each syringe having 6ml in syringe. There was no pharmacy label on the Heparin flush that included a resident name or directions. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/11/24 at 4:16 PM with the Medical Director regarding heparin flush being used in SASH method after PICC IV antibiotic infusion for Resident #8, he stated I did not order that. I was not aware. He stated that administration of heparin flush in PICC is always a risk of bleeding. He stated his expectation is that a nurse should not administer anything without an order and doing so could cause harm. In an interview on 12/11/24 at 4:44 PM with RNC she stated that her expectation for medication I expect them (facility staff) to check the physician orders, make sure nothing has changed, I expect orders to be checked and followed. I expect for them to be given within the time frame unless the resident is requesting different. She further stated, I probably don't have a specific administration thru a PICC line policy, they should the generalized IV medication administration policy. She stated that there are no standing orders for PICC lines, nor is the SASH method (saline, antibiotic, saline and heparin flush) facility protocol. She further stated that her expectation is not to administer a medication like heparin flush without an order. She further stated that she expects the physician to be contacted. She stated an Adverse outcome of Resident receiving heparin flush without order the resident could have issues with her blood clotting. She stated that she was not aware that heparin flush was administered. She verified that the heparin flush prefilled syringe on the medication cart had 6ml per syringe. In a telephone interview on 12/12/24 at 10:07 AM with Pharmacist, he stated that the pharmacy only sends Heparin flushes if it is specifically ordered for a resident by a physician or for the facility's emergency kit. He stated a staff member would need an order to access medication in emergency, and that would be patient specific. In an interview on 12/12/24 at 4:28 PM ADM stated that medications are to be given only with a physician's order. The ADM stated that an allergic reaction could be an adverse outcome of giving someone a medication without a physician order. Record review of LVN A personnel file revealed Validation Checklist for Flushing and Locking Central Venous Access/Midline/PICC Catheter dated 9/12/24 revealed that nurse was satisfactory in procedure observed and included Reviewed care plan and orders and Lock CVAD's with either preservative-free 0.9% sodium chloride or heparin flush 10units/ml (or according to manufacturer's directions). Record review of facility policy, Specific Medication Administration Procedure, dated 06/21/2022 indicated the following [in part]: C. Review 5 Rights (3) times: 1. Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order. b. Note any allergies or contraindications the resident may have prior to drug administration. c. If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. d. Check for vital signs, other tests to be done during/prior to medication administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Prepare resident for medication administration. 2. Prior to removing the medication from the container a. Check the label against the order on the MAR. b. Note any supplemental labeling that applies (fractional tablet, multiple tablets, volume of liquid, shake well, give with another medication, etc.). c. Due to the complexity and length/amount of instructions, some medications may be labeled use as directed. Refer to the MAR for instruction details. Record review of Drugs.com accessed on 12/18/24 at Heparin flush Uses, Side Effects & Warnings revealed in part: Heparin flush is used to flush (clean out) an intravenous (IV) catheter, which helps prevent blockage in the tube after you have received an IV infusion Heparin flush is injected directly into the catheter lock of your IV (intravenous) line. You may be shown how to use heparin flush at home. Do not use heparin flush if you do not fully understand how to flush your IV line and properly dispose of used needles, IV tubing, and other items used to inject your medicines. Follow your doctor's instructions.

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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. 50133 Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were secured in locked compartments and permit only authorized personnel to have access to the keys for 1 of 2 medication carts observed for medication storage. The facility did not ensure the East Hall Medication Cart was locked and secured. This failure could place the residents at risk of gaining access to unlocked medications not prescribed to them. Findings included: Observation on 12/10/2024 at 11:38 AM revealed the medication cart for east hall was found unlocked, lock was in unlock position, with the drawers easily opened by hand, parked in the hallway outside of a resident's room. There was no nurse in line of sight of medication cart. The medication cart was unattended. LVN A was in a resident's room and unable to see the medication cart. Medications in the cart included prescription medications, over the counter medications and narcotics. A resident was within 6 feet of medication cart in hallway. In an interview on 12/10/2024 at 11:40 AM LVN A stated she that she had forgotten to lock the medication cart when she went into a resident's room to administer medications. She also stated that she could not see the cart from inside the resident's room. She further stated that the medication cart is to be locked at all times when not in use by the nurse. She continued to state that lack of medication cart security could allow other residents access to the cart and the ability for residents to take medications. LVN A stated that she is responsible for security of her assigned medication cart. In an interview on 12/11/2024 at 4:44 PM RNC revealed that her expectation is for medication carts to be locked if not in use by nurse. She further stated that lack of cart security could allow any resident and/or staff to have access to the medications and contents of cart that are not prescribed to them. RNC stated that the nurse assigned to the medication cart is responsible for security. Record review of facility policy Specific Medication Administration Procedures dated 6/1/2022 revealed the following [in-part]: Procedures: A. Security: All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50133 Based on observation, interview and record review, the facility failed to ensure 1 of 31(East Hall room [ROOM NUMBER]) provided a minimum of 80 square feet of floor space per resident, in that: East hall room [ROOM NUMBER] was included in the facility's licensed capacity as a three-bed resident room and did not provide the minimum floor space required per resident. This failure could place residents at risk for restricted movement and limit the amount of resident use equipment and personal effects that could be accommodated in the room. The findings included: Review of the Bed Classifications Form 3740, signed and dated by the facility Administrator on 12/10/24, revealed resident room [ROOM NUMBER], located on the East Hall, was licensed for three beds and was categorized as Title 18 (Medicare). In an interview on 12/10/24 at 12:47 PM, the Administrator stated East Hall room [ROOM NUMBER] is considered under licensure as a 3-bed ward but is used for therapy, was a 3-bed ward. She stated she wanted to continue the room size waiver that was in effect for the room. Observation on 12/12/24 at 10:20 AM, accompanied by Life Safety Code surveyor and the facility's Maintenance Director, revealed Room #E15, was used by the therapy department and contained therapy equipment and a desk. Room #E15 is licensed as a 3-bed ward. The room floor space was measured at 221. 8 square feet and equaled 73.9 square feet per person.