STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675181	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage House Manor	210 Pipeline Rd Sulphur Springs, TX 75482

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility has failed to ensure that the resident environment remains as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 1 of 4 residents reviewed for accidents. (Residents #3) The facility failed to ensure Resident #3 had on a Wanderguard (bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time) leading him to be able to elope out of the door at the end of the 400 Hall. This failure could place residents at risk of injury from accident and hazards. Findings included: 1. Record review of the face sheet dated 06/12/24 revealed Resident #3 was [AGE] years old and admitted on [DATE] with diagnoses including stroke, dementia, and anxiety disorder. The face sheet revealed Resident #3 was discharged on [DATE]. Record review of the quarterly MDS dated [DATE] revealed Resident #3 was discharged to the hospital on 05/07/24. The MDS revealed Resident #3 had a BIMS score of 00 which indicated severe cognitive impairment. The MDS indicated Resident #3 was independent with ADLs. The MDS revealed the resident required substantial/maximal assistance with chair/bed-to-chair transfers and the resident used a wheelchair. Record review of the care plan last revised on 04/22/24 did not indicated Resident #3 was an elopement risk or required a Wanderguard. Record review of an Elopement Risk Alert dated 09/30/20 indicated Resident #3 had dementia with behaviors. The areas/places to focus search indicated, .will try to get home .angry with family for moving him to SNF . Record review of an Elopement Risk assessment dated [DATE] indicated Resident #3 had an elopement risk score of 10. The assessment indicated a resident with a score of 10 or greater was an elopement risk. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Elopement Risk assessment dated [DATE] indicated Resident #3 had an elopement risk score of 12. The assessment indicated a resident with a score of 10 or greater was an elopement risk. No other Elopement Risk Assessments for Resident #3 were provided by the facility prior to exit. Record review of a Wanderguard, Personal Alarms, and Door Alarm Log for 05/2023 and 06/2023 indicated there was no documentation of Resident #3's Wander Guard being checked on 05/10/23, 05/12/23, 05/15/23, 05/17/23, 05/19/23, 05/22/23, 05/24/23, 05/26/23, 05/29/23, 05/31/23, 06/02/23, 06/05/23, 06/07/23, 06/09/23, 06/12/23, 06/14/23, 06/16/23, 06/19/23, 06/24/23, 06/23/23, 06/26/23, and 06/28/23. Record review of a Provider Investigation Report dated 06/30/23 indicated Resident #3 eloped from the facility on 06/29/23 at 10:30 p.m. The report indicated Resident #3 had dementia with behaviors and exit-seeking was a new behavior. The report indicated Resident #3 exited a hallway door at 10:30 PM without staff noticing. He was outside until 10:45 when staff heard him at the front door . A Wander Guard alert tag was immediately placed on the resident so that hallway exits will delay egress and sound an alarm if the resident seeks exit. The Investigation Summary indicated, Surveillance video was reviewed. The resident experienced no injury or adverse events. He let himself out of the building . Record review on an Intake Investigation Worksheet with a received date of 06/30/23 concerning Resident #3 indicated, .The resident had no injuries upon assessment .the resident eloped through the laundry room exit at 10:38 PM, and staff did not discover it until he was heard at the front door at 10:53 PM .The resident has not tried to elope in a few years and did not have a Wander Guard device on at the time . The intake was a facility reported incident reported by the Administrator. During an interview on 6/12/24 at 1:03 p.m., LVN E said on the evening of 06/29/23 they had put Resident #3 to bed, but he had gotten back up. She said he always wandered. She said she was charting. She said she looked up and he was gone. She said an alarm never went off. She said she could not remember but he may not have had a wander guard on. She said she did not know why he did not have one on. She said staff began looking for him because they did not see him. She said they found him outside the exit door at the end of the 500 Hall. She said he was still in his wheelchair. She said he had no injuries. She said, He was perfectly fine. She said no staff witnessed him outside. She said, as far she knew, he never left the property. She said he was not sweaty or hurting. She said after that, they increased supervision for Resident #3. She said someone told her he had been to the hospital and his Wanderguard had been cut off . She said she knew he would refuse to have his Wanderguard checked at times. During an interview on 6/12/24 at 2:05 p.m., the DON said she was notified by staff that Resident #3 had eloped when staff discovered he was missing. She said the Administrator had completed the investigation. She said there were cameras outside, and he never left the property. She said he had no injuries. She said he had a Wanderguard after he was admitted . She said the nurse said he had been to the hospital and the hospital cut it off. She said the nurse said the Wanderguard had not been replaced before he eloped. She said there was no documentation during the month of June 2023 that he had been out to the hospital, and he did have his Wanderguard on. (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 06/12/24 at 2:54 p.m., CNA E said on the evening of 06/29/23, Resident #3 could not sleep and wanted to get up. She said he was moving around at the nurse's station. She said he was in a good mood. She said it had not been less than 5 minutes and suddenly she did not see him. She said she did not hear an alarm. She said they began looking down each hall for him. She said it did not take long at all. She said they could hear him making sounds outside. She said they followed his voice. She said he had gone out the door on the 400 Hall. She said he never left the property. She said he had no injuries. She said he was not hot. She said he was found very quickly. She said he was not upset and did not realize what was going on. She said she did not know anything about the Wanderguard.

During an interview on 6/13/24 at 11:36 p.m., the Maintenance Supervisor said if a resident had a Wanderguard on, the door at the end of the 400 Hall would still open but would alarm. He said he was unaware of any doors malfunctioning over the last year. He the nursing staff checked to make sure the Wanderguards were working. He said it had never been reported to him that a Wanderguard was malfunctioning. He said to his knowledge the door had no issues in the last year.

During an interview on 6/13/24 at 12:16 p.m., CNA F said on the evening of 06/29/23, Resident #3 was talking to her. She said she went to make her rounds and when she came back he was gone. She said the door never alarmed. She said she started looking for him. She said she started her rounds at ten. She said it was at least 30 minutes before she realized he was missing. She said he was found out beside the building near the 500 Hall. She said he looked fine. She said there was nothing wrong with him. She said he was in no distress. She said he never left the property. She said she was amazed he got as far as he did. She said he normally stayed around the nurse's station.

During an interview on 6/13/24 at 12:38 p.m., Restorative Aide G said it was her responsibility to make sure all Wanderguards were working. She said she was told that Resident #3 did not have on a Wanderguard on 06/29/23. She said it had been a long time and she could not remember. She said she did not know why he would not have had on his Wanderguard. She said she checked all residents with Wanderguards on Mondays, Wednesdays, and Fridays. She said she wheeled each resident to each door to make sure they were working. She said a Wanderguard did not cause the door on the end of the 400 Hall to lock, but it would alarm if someone with a Wanderguard went out.

During an interview on 06/13/24 at 1:26 p.m., the DON said only the front door and the dining hall door locked with Wanderguards and all doors alarm after hours when anyone goes out . She said she thought the time began at 6 p.m. She said only the glass door going to the laundry room did not alarm during the day. She said she did not know why Resident #3 did not have his Wanderguard on. She said she would assume he had been out to the hospital, and it would have been cut off. She said she had found no hospital records for the month of June 2023 that would indicate he had been out. She said right after the incident, staff told her they did not know if he had it on. She said she did have staff verify he had it on, but she did not know the date. She said the only elopement risk assessments was the one from October 2020 and the one done March 2024. She said a resident that eloped, obviously they could die, heat exposure, cold exposure, and vehicles. She said there had been no other elopements since 6/29/2023.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/24 at 2:17 p.m., the Administrator said Resident #3 went out the door at the end of the 400 Hall on the night shift. She said he went out in his wheelchair and no alarms sounded. She said she watched him leave on a video and she was able see he went around the side of the building. She said he never left the property. She said staff told her he did not have a Wanderguard on when he went out. She said a resident that eloped could have been injured or gotten lost. During an observation on 6/13/24 at 2:20 p.m., the CNA Supervisor, in presence of the DON, wheeled a resident with a wander guard in a wheelchair just out the 400 Hall outside door and the alarm sounded and they had to put a code in to silence the alarm. Review of a Wandering and Elopements facility policy last revised in March 2019 indicated, .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents . if identified at risk for wandering, elopement, or other safety issues, the resident's care plan would include strategies and interventions to maintain the resident's safety .

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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 46062

Based on observation, interview, and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 5 residents (Resident #1) reviewed for pharmacy services.

The facility failed to ensure LVN A followed the facility's Administering Medications policy which resulted in Resident #1 receiving Resident #2's hydrocodone/APAP 7.5 mg/325 mg tablet (opioid analgesic medication used to treat pain) that was not prescribed to her.

This failure could place residents at risk of receiving incorrect medications, dosages of medications , and significant adverse effects from medication errors.

Findings included:

1. Record review of Resident #1's face sheet dated [DATE] revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including dementia (forgetfulness that interferes with daily functioning), cognitive communication deficit, muscle weakness, repeated falls, and chronic pain.

Record review of Resident #1's annual MDS assessment dated [DATE] revealed she was usually understood and usually understood others. Resident #1 had a BIMS score of 5, which indicated she had severe cognitive impairment. Resident #1 was independent with most ADLs. Resident #1 received as needed pain medications for frequent pain that rarely affected her day-to-day activities.

Record review of Resident #1's care plan with a start date of [DATE] revealed she rarely had pain and had interventions including to administer medications as ordered and monitor her for side effects and effectiveness of her medications and contact her physician as needed. Resident #1 was at risk for falls.

Record review of Resident #1's Physician Orders dated [DATE] revealed an order for Tramadol 50 mg (opioid analgesic medication used to treat pain) by mouth every four hours as needed for pain with a start date of [DATE].

Record review of Resident #1's Med Aide EMAR dated [DATE] revealed there was no documentation indicating Tramadol 50 mg by mouth had been administered [DATE]-[DATE].

Record review of Resident #1's Departmental Notes dated [DATE]-[DATE] revealed there was no documentation of Resident #1 complaining of pain or being administered a medication for pain on the 6 PM to 6 AM shift on [DATE]-[DATE].

Record review of Resident #1's Individual Patient's Antibiotic/Narcotic Record for Tramadol 50 mg tablets revealed the tablets expired on [DATE] and there was no documentation of medications given after that time.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on [DATE] at 2:30 PM, Resident #1 was clean and well groomed. She said she did not have any pain at the time. Attempted to notify Resident #1's RP on [DATE] at 3:02 and [DATE] at 12:44 PM, there was no answer, and a voicemail was left. Resident #1's RP did not return call prior to exiting the facility. 2. Record review of Resident #2's face sheet dated [DATE] revealed he was [AGE] years old and admitted to the facility initially on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses including fistula of stomach and duodenum (abnormal opening in the stomach or intestines that allows contents to leak into another part of the body), cognitive communication deficit, and chronic pain. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he was usually understood and understood others. Resident #2 had a BIMS of 11, which indicated he had moderate cognitive impairment. Resident #2 used a wheelchair for mobility and was dependent on staff assistance with most ADLs. Resident #2 received scheduled pain medications for occasional pain that occasionally affected his sleep and rarely affected his day-to-day activities. Record review of Resident #2's care plan with a start date of [DATE] revealed he had contractures to his right upper extremity and both lower extremities with interventions including pain medications as ordered and pain assessment per orders. Resident #2 was at risk of falls. Record review of Resident #2's Physician Orders dated [DATE] revealed an order for Hydrocodone 7XXX, d+[DATE] mg by mouth every six hours for pain with a start date of [DATE]. Record review of Resident #2's Med Aide EMAR dated [DATE] revealed he received hydrocodone/APAP 7.5 mg/325 mg by mouth every six hours (4:00 AM, 10:00 AM, 4:00 PM, and 10:00 PM) for pain with a start date of [DATE] and it was discontinued [DATE]. Record review of Resident #2's Individual Patient's Antibiotic/Narcotic Record for Hydrocodone 7.5 mg/325 mg revealed LVN A had administered 1 tablet to Resident #2 on [DATE] at 10:00 PM and 1 tablet on [DATE] at 5:00 AM. Resident #2's hydrocodone tablet count should have been 46, but there was a count of 45 circled by LVN A, indicating the count was wrong. During an observation and interview on [DATE] at 2:45 PM, Resident #2 was lying in bed and was clean and well groomed. He said he received routine pain medication, and his pain was managed. (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 [DATE] at 12:10 PM, LVN B said she was the oncoming nurse on [DATE] AM shift and counted narcotics with LVN A, who was the outgoing nurse from the night shift. LVN B said the count was wrong and it was her first day back on duty. LVN B said the count was wrong and she did not accept the cart keys, and she notified management the narcotic count was off by one hydrocodone for Resident #2. LVN B said she was instructed to start drug testing staff with access to that cart. LVN B said they tested LVN A and all staff that had been in that medication cart for the three days prior. LVN B said all staff were negative. LVN B said she did not know the outcome of the investigation. LVN B said the oncoming nurse counts the narcotic medications with the outgoing nurse each shift change, and then they sign the sheet together indicating the count was correct. LVN B said if the narcotic count was wrong, then the oncoming nurse should not accept the medication cart keys and then notify management. LVN B said if a resident voiced, they wanted something for pain, the nurse should have the resident rate their pain level. LVN B said she did not trust the computer and she always checked what the computer said the last medication dose was against what the narcotic log said the last dose was. LVN B said she would ask the resident their name if they were alert and oriented or use the picture in the chart to identify the resident. LVN B said staff should check the MAR, dose, route, and check the medication card for correct resident and correct medication/dose prior to administering a medication to a resident. LVN B said there should be name alert sticker (big orange sticker) on the medication cards to give staff a clue there were multiple residents with the same last name. During an observation and interview on [DATE] at 1:00 PM, MA C unlocked her cart for Hall 5 and the narcotic box, viewed Resident #2's medication card for hydrocodone, followed by Resident #2's medication card for Zolpidem, and then followed by Resident #1's medication card for Tramadol. There were no name alert stickers on the cards. MA C said the nurses count the narcotics when the nurses come in during the 6 AM or 6 PM shift changes. MA C said then she counts again with the nurse when she comes in at 8 AM before accepting the cart keys. MA C said she would count again with the nurse before going off duty. MA C said she ensured the correct medication was given to the correct resident by following the five rights of medication administration by verifying the right patient, medication, dose, frequency, and route. MA C said if a resident was given a medication that was not prescribed, it could lead to adverse reactions or side effects for the resident, or they could be allergic to the medication. During an interview on [DATE] at 1:56 PM, the DON said Resident #2's hydrocodone count was wrong at the end of the night shift. LVN A was coming off the night shift and she could not place where Resident #2's hydrocodone had gone, so it was reported. The DON said video surveillance showed LVN A took the hydrocodone to the wrong room to Resident #1. The DON said everything was signed out as if the hydrocodone was for Resident #2, however, LVN A took it to Resident #1 and administered the hydrocodone to Resident #1. The DON said they had name alerts with stickers for their paper charts and then a name alert was in the electronic chart also. The DON said they did not place name alert stickers on the medication cards. The DON said the risk of receiving a medication that was not ordered for the resident, could result in adverse drug reactions, allergies, and possible death. During an interview on [DATE] at 2:30 PM, the ADM said they watched LVN A on the video surveillance sign the medication out and walk it to Resident #1's room and not Resident #2, which left his hydrocodone count short one pill. The ADM said the effect of receiving a medication that was not prescribed to a resident would depend on the medication, but it could affect the resident and counter react with other medications. (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 interview on [DATE] at 2:49 PM, LVN A said Resident #1 had requested something for pain. LVN A said she mistakenly pulled Resident #2's card of hydrocodone and administered one tablet to Resident #1. LVN A said she was honestly just not paying attention and pulled the wrong card. LVN A said both residents have the same last name. LVN A said she had never given Resident #1 anything for pain and did not even realize she had anything for pain. LVN A said she should pay more attention when administering medications. LVN A said she usually signed the medications out and she checked the orders to make sure the resident had something for pain. LVN A said she was aware of the five rights of medication administration, which included verifying the right resident, right medication, right dose, right time, and right route. LVN A said Resident #1 was administered a medication that was not prescribed to her, and the medication placed the resident at risk of having an allergic reaction to the medication, the medication could have been too strong, and it could have suppressed her breathing. LVN A said she did not realize she had done it until she and LVN B were doing the narcotic count at shift change and Resident #2's hydrocodone was short one tablet. LVN A said she called the DON to report the hydrocodone count was short for Resident #2. LVN A said she did a drug test and then continued to try to figure out what happened. LVN A said she realized later what she did, and she called the DON and then the DON and the ADM watched the video surveillance cameras and confirmed what happened. LVN A said she had taken a hydrocodone from Resident #2's medication card and administered it to Resident #1. LVN A said they continued to monitor Resident #1 for two days to monitor for any adverse reactions. LVN A said Resident #1 did not have any reactions to the hydrocodone. Record review of the facility's Medication Error Report dated [DATE] revealed Resident #1 was given Norco (hydrocodone) 7XXX,d+[DATE] mg from a resident's medication with the same last name across the hall, who did have an order for it. The report indicated Resident #1 did not have any adverse reactions from the Norco. The Assessment and Summary of the Error indicated the type of error was wrong resident and the reason for the error was failure to identify resident. Record review of the facility's policy titled Administering Medications, dated revised on [DATE] stated . medications were administered in a safe and timely manner, and as prescribed . medications were administered in accordance with the prescribers orders . the individual administering medications verifies the resident's identity before giving the resident his/her medications . methods of identifying the resident include . checking identification band . checking photograph attached to the medical record . and if necessary, verifying resident identification with other facility personnel . the individual administering medication checks the label THREE times to verify the right resident, right medication, right dosage, right time, and right method/route of administration before giving the medication . as required or indicated for a medication, the individual administering the medication records in the resident's medical record . the date and time the medication was administered, the dosage, route of administration . any complaints or symptoms for which the drug was administered . any results achieved and when those results were observed . and signature and title of person administering the drug . medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the director of nursing services .