STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675201	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Medical Lodge	300 S. Highway 36 Bypass Gatesville, TX 76528

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** 47772 Based on observations, interviews and record review, the facility failed to provide pharmaceutical services to meet the needs of each resident for 1 of 4 Residents (Resident #1) reviewed for pharmaceutical services. MA A administered a non-prescribed 5 MG of Buspirone (a medication for anxiety) and non-prescribed 400 MG of Magnesium Oxide (a medication for heartburn, sour stomach, or acid indigestion) to R #1 on 11/14/2024. The noncompliance began on 11/14/2024 and ended on 11/14/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at the facility at risk of medication errors. Findings included: RR of R#1's AR, dated 1/28/2025, reflected a [AGE] year-old woman who admitted to the facility on [DATE]. She was diagnosed with Paroxysmal Atrial Fibrillation (which was a disease of the heart characterized by irregular and often faster heartbeat.) RR of R#1's Quarterly MDS, dated [DATE], reflected the resident had a BIMS Score of 12. A BIMS Score of 12 indicated the resident had moderate cognitive impairment. RR of a complaint, dated 11/15/2024, reflected R #1 was given a non-prescribed medication, in error, on 11/14/2024. The complaint alleged MA A, who was administering medications, was not being watched by the trainer at the time of the alleged medication error. (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RR of R #1's PN, in the resident's medical record, reflected a telehealth (video conference) visit, dated 11/14/2024 at 6:30 PM. The chief complaint was [R #1 received 5 MG of Buspirone and 400 MG of Magnesium Oxide. Physician subjective view was patient had no complaints, was seen on video, appeared non-distressed, denied chest pain or shortness of breath. Alert and oriented to time and place, following all commands appropriately. All vital signs were stable; BP generally runs lowish (Blood Pressure 100/57, Pulse 78, Oxygen Saturations 95%.) Denied lightheadedness or dizziness. Assessment/Plan inadvertent medication given to the patient, she received 5 MG of Buspirone and 400 MG of Magnesium Oxide about 20 minutes ago, alert, and oriented, non-sedated, no complaints, following all commands, vital signs stable, LVN was asked to monitor Vitals every 2 hours for 6 hours, cardiorespiratory, neuro checks per protocol. Call back if any concerns of cardiopulmonary depression or oversedation. Advised to hold tonight's Remeron (an anti-depressant sometimes used to stimulate hunger) and Melatonin (a medication used to help someone fall asleep) given potential sedation with 5 MG of Buspirone and 400 MG of Magnesium Oxide.] RR of a facility generated Medication Error Report, dated 11/14/2024 at 6:20 PM, reflected R #1 received a medication error on 11/14/2024. MA A administered the incorrect medication. Description of event: MA A was completing final checks on medications; trainer had clicked to next resident to start reviewing medications and MA A thought that was who she was giving medications. What contributed most to this error, was not confirming the 5 rights of medication administration. To prevent an error from happening again, MA A had education provided with additional days of training. The telehealth physician ordered withhold Remeron and Melatonin. RR of a facility generated Confidential Employee Corrective Action Form, dated 11/14/2024, reflected MA A received a coaching. Reason: Employee completed a medication error and gave medications to wrong patient. Conduct that was observed, or substantiated: 5 rights of medication administration were not followed. Areas to improve: MA A to be provided additional days of training. Signed by MA A, and the ADM, on 11/15/2024. RR of MA A's medication aide permit in Tulip (Texas Unified Licensure Information Portal) reflected an issue date of 11/4/2024; Expiration date of 11/4/2025. RR of MA A's medication administration check off form, dated 11/13/2024, reflected the MA met required tasks. INT and OBS on 1/28/2025 at 9:44 AM with R#1 revealed her in her wheelchair about to exit her room. She was fully dressed, appropriately groomed, and easy to engage. R #1 recalled the medication error from 11/14/2024. She stated the facility addressed the medication error when it happened. She did not want to discuss it further and refused further interview. Resident alert, cordial, and lucid. INT and OBS on 1/28/2025 at 9:44 AM with MA B revealed she was trained to be an MA per policy, continuing education, and yearly reviews. She was observed, at med pass, looking at medication packaging and checking the information on the computer. She stated she was making sure the right medication made it to the right resident and was part of the 5 Rs (Rights) of medication administration. She did not recall any medication errors recently; Any medications errors were reported immediately. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INT and OBS on 1/28/2025 at 10:07 AM with MA C revealed she went to school, to become an MA, for about three months and participated in supervised clinicals. There was training throughout the year and yearly check offs were performed. She stated she was trained to check the 5 Rs for accurate medication administration. The 5 Rs were right person, right time, right dose, right medication, and right route. She did not recall any medication errors recently; Any medications errors were reported immediately. INT on 1/28/2025 at 11:33 AM with R #1's NP revealed that 5 mg of Buspirone was a small dosage of a gentle anti-anxiety medication. The goal, for this medication, was to take it multiple times a day to build up the anti-anxiety effect. The NP did not think the individual 5 MG of Buspirone would have had much of a negative effect on the resident, if any. She may have had a slight headache, or some nausea, but it was unlikely the medication error caused her any significant harm. The Magnesium 400 MG was a medication for upset stomach, or constipation. The dosage R #1 received, was a normal dosage. The resident may have suffered diarrhea, if she received more of the medication, but the initial, and singular administration, probably did not have any significant effect. The NP did not recall the resident to have had any complaints. INT and RR on 1/28/2025 at 12:11 PM with the DON revealed new medication aides go through orientation, when hired, and all medication aides went through specific training to become authorized to pass medications. After the medication error on 11/14/2024, the DON stated the MA A was taken off nights and went to day shift for an additional 3 more days of training. After the 3 additional days, MA A transitioned back to the night shift. The DON stated there were no medication errors since 11/14/2024. RR of the medication error binder reflected no medication errors since 11/14/2024. The DON felt the incorrectly administered Buspirone 5 MG may have made the resident drowsy, but the resident did not have any significant negative effect. The Magnesium Oxide 400 MG was a normal dosage. The Magnesium Oxide 400 MG could have caused loose stools, but the resident only had one dose and did not exhibit any significant gastrointestinal or bowel concerns. Safeguards in place to avoid medication errors were the MA training, MA skill check offs, and on-the-spot checks by senior staff. INT on 1/28/2025 at 1:15 PM with the ADM revealed facility medication aides were trained to administer medications per policy. The ADM felt the facility medication administration policy and the training MA A received addressed the appropriate information to avoid medication errors. The failure that caused R #1 to receive a non-prescribed medication fell upon communication and human error. Safeguards in place to prevent medication errors were the training program, nurse management monitoring, continued education, and yearly reviews. RR of the facility's Medication Administration Policy, undated, reflected the MA was supposed to have identified the correct resident prior to medication administration; supposed to have read medication orders on medication sheet; remove medication container and compare label with medication sheet; place appropriate dosage in cup; re-read label and medication sheet. Repeat procedure with each resident who was supposed to receive medication. RR of the facility's in-service education for 5 rights of Medication, dated 11/14/2024, reflected 20 staff, from both AM and PM shifts, in attendance. MA A was in attendance, marked by signature.