STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Greenbrier Nursing & Rehabilitation Center of Tyle		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 W Erwin St Tyler, TX 75702	

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 - Some	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** 41093 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 2 of 5 residents (Resident #1 and Resident #2) reviewed for pharmacy services. The facility failed to accurately transcribe Resident #1's morphine (narcotic medication used to treat pain) which resulted in him receiving an incorrect dosage of the medication. The facility failed to accurately transcribe Resident #2's medication orders for lorazepam (a benzodiazepine medication used to treat anxiety), tramadol (an opioid analgesic used to treat pain) and oxycodone (an opioid analgesic medication used to treat pain. These failures could place residents at risk of receiving incorrect dosages of medications and significant adverse effects from medication error. Findings included: 1.Record review of the face sheet for Resident #1 dated [DATE] indicated he was [AGE] years old admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, high blood pressure, high cholesterol and pneumonitis (lung inflammation) due to inhalation of food and vomit. Record review of the MDS dated [DATE] indicated Resident #1 sometimes made himself understood and usually understood others. The MDS indicated he had severe cognitive impairment (BIMS of 4). The MDS indicated Resident #1 had no behavior of rejecting care. The MDS indicated he was always incontinent of bowel and bladder. The MDS indicated Resident #1 had an active diagnosis of non-traumatic brain dysfunction. The MDS indicated Resident #1 had received scheduled pain medication. The MDS indicated Resident #1 had not received any prn pain medication during the 5 day look back period. The MDS indicated Resident #1 had condition or chronic disease that may result in a life expectancy of less than 6 months. The MDS indicated Resident #1 was on Hospice care. Record review of Resident #1's care plan dated [DATE] indicated he had a potential for uncontrolled pain. The care plan interventions included, evaluate the effectiveness of pain interventions; alleviating of symptoms and monitor/record/report to nurse any signs/symptoms of non-verbal pain. The care plan also indicated Resident #1 had a terminal prognosis. The care plan interventions included, work with hospice services cooperatively to ensure resident's needs were met. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the physician order with a start date of [DATE] indicated Resident #1 was to be administered Morphine 100mg/5 ml, give 2 ml sublingually every hour as needed for pain. Record review of Resident #1's MAR for [DATE] revealed Resident #1 had not received any as needed Morphine in the month of [DATE]. Record review of Resident #1's MAR for [DATE] indicated Resident #1 had received the as needed 2 ml dose (40 mg) of Morphine 100 mg/5ml on [DATE] at 2:50 p.m. and on [DATE] at 11:36 a.m. There were no other administrations of the as needed 2 ml dose of Morphine 100 mg/5ml in the month of [DATE]. Record review of Resident #1's photographed prescription medication bottle of Morphine 100 mg/per 5 ml (20 mg/ml), received on [DATE] displayed the following instructions take ,d+[DATE] mg (0XXX,d+[DATE]ml) by mouth or under the tongue every hour as needed for pain or dyspnea. During an interview on [DATE] at 8:22 a.m., Hospice nurse A said Resident #1 had been in the in-patient hospice facility from [DATE] to [DATE]. Hospice nurse A said Resident #1 was admitted to nursing facility with continuation of hospice services on [DATE] with diagnosis of advanced Alzheimer's disease. Hospice nurse A said on [DATE] the weekend hospice nurse had made a as needed visit to the facility, at the nursing facility's request to see Resident #1. Hospice nurse A said the nurse that made the as needed visit had determined at that time ([DATE]) Resident #1 was actively dying. Hospice nurse A said on [DATE] she made a routine visit to see Resident #1 at the nursing facility as was done when a patient was actively dying. Hospice nurse A said LVN B reported to her she had administered 2 ml of morphine to Resident #1 for pain earlier in the day. Hospice nurse A said she asked to see the MAR because 2 ml's was not the usual ordered dose. Hospice nurse A said when she saw that the morphine was listed as 2 ml on the MAR she asked to see the order, which LVN B displayed on the EMR system. Hospice nurse A said she then asked to see the original order from Hospice as the entered order was incorrect. Hospice nurse A said the orders were not located but the DON was notified, and the error was corrected (the order was entered correctly) to 0.5 ml to 1 ml as needed for pain verses the 1ml-2ml order that had been entered. Hospice Nurse A said the hospice physician was also notified. Hospice nurse A said Resident #1 was readmitted to the hospice in-patient facility on [DATE] and remained in hospice facility until he passed on [DATE]. Hospice nurse A said Resident #1 was readmitted to the inpatient hospice facility because after the medication error the facility had asked for scheduled pain medication orders only vs the scheduled and prn orders he had. Hospice nurse A said when the hospice physician was notified of the facility request he advised to have the resident admitted as in-patient to the hospice facility. Record review of the hospice nursing note dated [DATE] at 10:58 p.m., revealed Resident #1's respirations at the time of the visit were 24 breaths per minute and documented he (Resident #1) was in active dying status. (continued on next page)

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Greenbrier Nursing & Rehabilitation Center of Tyle	3526 W Erwin St Tyler, TX 75702

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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 - Some	During an interview on [DATE] at 9:40 a.m., LVN B said she had administered both doses of morphine to Resident #1 ([DATE] at 2:50 p.m. and on [DATE] at 11:36 a.m.). LVN B said Resident #1 had declined since his admission to the facility on [DATE]. LVN A said when Resident #1 first arrived to the facility he could talk and visit with everyone but as the weeks went on he did not talk or speak when he had visitors and did not coherently respond to staff. LVN B said on [DATE] Resident #1 was moaning and thrashing in the bed and his respiratory rate was elevated. LVN B said he (Resident #1) was clearly in pain and she checked the MAR to see what he had available. LVN B said she administered the morphine 2ml as it was ordered/as the order appeared on the MAR. LVN B said when she re-assessed Resident #1 after the morphine administration about 1 hour later, he was no longer moaning, grimacing or thrashing although his respiratory rate was still elevated at 22 breaths per minute. LVN B said when she gave the medication on [DATE] and Resident #1 was displaying the same symptoms of pain as the day before. LVN B said when she reassessed Resident #1 after the 2nd administration on [DATE], Resident #1 seemed comfortable as he was not grimacing, thrashing, moaning and his respirations were normal at a rate 16. LVN B said she had no idea the dose of the morphine was incorrect until Hospice nurse A told her it was more than the usual dose given because it was listed on the MAR and the order in the EMR system. LVN B said the order had apparently been entered incorrectly. During an interview on [DATE] at 10:30 a.m., the hospice pharmacist said the extra 20 mg of morphine (dose of 40 mg) Resident #1 received on [DATE] did not push him into active dying or cause his death. The pharmacist said the morphine administered by the facility nurse at 2:50 p.m., would have been out of his system by the time he was visited by the hospice nurse. The pharmacist said the additional 20 mg received on [DATE] (another dose of 40 mg) would not have had a cumulative effect as again the previous dose of morphine administered on [DATE] would have been out of his system. The pharmacist said neither the dose on [DATE] nor the dose on [DATE] would have pushed Resident #1 into active dying or caused his death. The hospice pharmacist also pointed out Resident #1 died 5 days after the last administration given by the facility and in those 5 days was given another 80 mg of morphine at the inpatient hospice facility. Record review of the hospice medication list dated [DATE] revealed Resident #1 was to be administered Morphine 20mg/ml ,d+[DATE] mg by mouth or sublingual every 1 hour as needed for pain/dyspnea. Record review of the hospice admission orders dated [DATE] revealed no detailed medication orders were on the admission order and indicated there was a list of current medications attached. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:40 a.m., The DON said she could not provide the attached medication list as the facility had not attached a medication list and sent the medications only. The DON said a medication list was sent with the referral but was dated [DATE] and no additional med list was provided on [DATE]. The DON said LVN C was Resident #1's admitting nurse and would have admitted Resident #1 and entered his orders. The DON stated LVN C had to enter orders based on the orders/directions on the medication labels received from the hospice facility and made an error in entering the order. The DON said after the medication error was made she reviewed all new admissions since [DATE] and all current hospice residents to ensure the accuracy of entered orders. The DON said she also initiated an ongoing in-service for nurses and MA's related to verification of all orders to ensure the orders were transcribed correctly and to obtain clarification from the physician if necessary; medication five rights (the right patient, the right drug, the right time, the right dose, and the right route); and that all liquid morphine administration is to verified with a second nurse. The DON said the process for ensuring that medications were entered correctly from that point ([DATE]) was that herself and the ADON would double check all new admissions and new hospice residents to ensure their medications had been entered correctly by the admitting nurse. During an interview on [DATE] at 9:39 a.m., the facility Medical Director said No, not at all when asked if the extra 20 mg of morphine (40 mg dose) administered on [DATE] pushed Resident #1 into an active phase of dying. The Medical Director said the 2nd extra dose of 20 mg (40 mg dose) administered on [DATE] had absolutely not caused Resident #1's death or pushed him into active dying. The Medical Director said Resident #1 receiving and additional 40 mg of morphine in 20-hour period did not push Resident #1 into active dying nor caused his death. During an interview on [DATE] at 5:15 p.m., the inpatient hospice medical doctor said the neither the dose on [DATE] of an extra 20 mg nor the dose on [DATE] of an extra 20 mg administered by the facility would have pushed Resident #1 into active dying or caused his death. 2. Record review of the face sheet for Resident #2 dated [DATE] indicated she was [AGE] years old readmitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (neurological disorders not caused by primary structural abnormalities), heart failure, high blood pressure, dementia, and stage 3 kidney disease (a stage of chronic kidney disease in which the kidneys have mild to moderate damage, and they are less able to filter waste and fluid out of the blood). Record review of the MDS dated [DATE] indicated Resident #2 usually understood others and usually made herself understood. The MDS indicated Resident #2 had both short-term problems. The MDS revealed Resident #2 had moderately impaired cognitive skills for decision making. The MDS indicated Resident #2 had no behavior of rejecting care. The MDS indicated she required substantial/maximal assistance with eating, oral hygiene, and upper body dressing and was dependent on staff for toileting, showering/bathing, lower body dressing, personal hygiene and the putting on/taking off of footwear. The MDS indicated Resident #2 had received anti-anxiety medication during the 7-day look back period. The MDS did not indicate Resident #2 had been administered opioid medications during the 7-day look back period. The MDS did not indicated Resident #2 had received any as needed opioid or anti-anxiety medications. Record review of the Resident #2's care plan dated [DATE] indicated Resident #2 used anti-anxiety medications. The care plan interventions included give anti-anxiety medications as ordered by the physician. The care plan did not address Resident #2's opioid analgesic medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the hospice delivery of medications dated [DATE] indicated Resident #2 medication orders for as needed oxycodone and as needed lorazepam were as followed: *lorazepam 0.5 mg, *oxycodone 5 mg, and *tramadol 50 mg. The delivery of medications did not provide route, or frequency for any of the medications. Record review of the admission paperwork form the hospice provider dated [DATE], found no list of medication orders providing a route and frequency of the following medications: *lorazepam 0.5 mg, *oxycodone 5 mg, and *tramadol 50 mg. Record review of the physician order dated [DATE] indicated Resident #2 was to be administered tramadol 50 mg sublingually (put under the tongue) every 12 hours as needed for moderate pain. This order was entered by LVN C. This order was discontinued on [DATE]. Record review of the physician order dated [DATE] indicated Resident #2 was to be administered tramadol 50 mg orally (by mouth) every 12 hours as needed for moderate pain. This order was entered by LVN C. This order was discontinued on [DATE]. Record review of the physician order dated [DATE] indicated Resident #2 was to be administered oxycodone 5mg 1 tablet sublingually (put under the tongue) every 3 hours as needed for severe pain/dyspnea (shortness of breath). This order was entered by LVN C. This order was discontinued on [DATE]. Record review of the physician order dated [DATE] indicated Resident #2 was to be administered oxycodone 5mg 1 tablet orally (by mouth) every 3 hours as needed for severe pain/dyspnea (shortness of breath). This order was entered by LVN C. This order was discontinued on [DATE]. Record review of the physician order dated [DATE] indicated Resident #2 was to be administered lorazepam 0.5 mg 1 tablet sublingually (put under the tongue) every 3 hours as needed for severe anxiety/restlessness. This order was entered by LVN C. This order was discontinued on [DATE]. Record review of the physician order dated [DATE] indicated Resident #2 was to be administered lorazepam 0.5 mg 1 tablet orally (by mouth) every 3 hours as needed for severe anxiety/restlessness. This order was entered by LVN C. This order was discontinued on [DATE]. Record review of Resident # 2's MAR for [DATE], indicated she had not received any as needed lorazepam, as needed tramadol or as needed oxycodone (neither orally nor sublingually) from her re-admission on [DATE] to [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 11:00 a.m., Resident #2 was laying in her bed asleep. Her respirations were even, unlabored at a normal rate. Resident #2 displayed no signs or symptoms of pain or shortness of breath. During an interview on [DATE] at 12:15 p.m., LVN B said LVN C should not have entered the orders for the sublingual or oral administration for each of the medications (lorazepam 0.5 mg, oxycodone 5 mg, and tramadol 50 mg) separately. LVN B said after clarification with the physician was received one single order should have been ordered for each medication noting that the medication could be administered orally or sublingually. LVN B said because both the sublingual and oral dose were entered as separate orders, the medications display on the MAR as separate orders which could result in a nurse administering the medication orally then another nurse administering the medication sublingually before the ordered frequency time had elapsed, which could have resulted in Resident #2 receiving too much medication. LVN B said over medication with any of the medications was not likely as they were ordered prn (as needed) and therefore would only be administered when Resident #2 displayed symptoms of pain (re; tramadol and oxycodone) or symptoms of anxiety (re; lorazepam). LVN C said there was a risk of significant medication error never the less. During an interview on [DATE] at 12:30 p.m., the ADON said LVN C should not have entered the orders for the sublingual or oral administration for each of the medications (lorazepam 0.5 mg, oxycodone 5 mg, and tramadol 50 mg) separately. The ADON said because both the sublingual and oral dose were entered as separate orders, the medications displayed on the MAR as separate orders which could have resulted in a nurse administering the medication orally then another nurse administering the medication sublingually before the ordered frequency time had elapsed The ADON said this could have resulted in Resident #2 receiving too much medication. The ADON said the medication orders having been entered separately for oral route and sublingual route left too much room for error. The ADON said since she took on the role as the ADON approximately two weeks ago she was trying to review new admission/re-admissions to ensure medication reconciliation and order entry were completed correctly by the admitting nurse. The ADON said if she was in the facility at the time of a new admission, she would perform the reconciliation and order entry herself. The ADON said if she was not in the building, she tried to review any new admission/readmission that occurred in her absence upon return to the facility. The ADON said she may have been working the floor the day Resident #2 was admitted and could by why the incorrect order entry for Resident #2 was not identified prior to surveyor asking for Resident #2's hospice orders. The ADON said there was not a current plan in place to address order entry/reconciliation when she was on the floor (working as a staff nurse) as far as she knew. The ADON said she was not working as the ADON at the facility at the time of Resident #1's medication error. During an interview on [DATE] at 12:50 p.m., the DON said LVN C should not have entered the orders for the sublingual or oral administration for each of the medications (lorazepam 0.5 mg, oxycodone 5 mg, and tramadol 50 mg) separately. The DON said she was not sure why LVN C had entered each medication as two separate orders. The DON said she had corrected the orders today after the surveyor requested the hospice orders. The DON said because both the sublingual and oral dose were entered as separate orders, the medications displayed on the MAR as separate orders which could result in a nurse administering the medication orally then another nurse administering the medication sublingually before the ordered frequency time had elapsed The DON said this could have resulted in Resident #2 receiving too much medication. The DON said the medication orders having been entered separately for oral route and sublingual route left too much room for error. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with LVN C was attempted on [DATE] at 11:17 a.m., 12:20 p.m., 12:26 p.m., via phone, detailed message was left with each attempt. The interview was not completed as no return call was received prior to exit. Record review of the facility policy and procedure titled Medication Reconciliation, dated [DATE] stated .At any time a change is made to patient's medication regimen, practitioners must ensure the change is made carefully, is documented, and accords with prescribing instructions for the relevant medication. Medication reconciliation should be performed every time a patient is admitted to a facility. Medication review should occur upon SNF admission and may reduce the incidence of complications or adverse events from medication errors. If possible, the SNF should obtain a copy of the medical reconciliation performed at the time of the patient's discharge from his or her prior care site .A pharmacist is on call at all times and can be contacted for any questions . Record review of the facility policy and procedure titled Medication Orders, dated 2003, stated .(b) any dose that appears inappropriate .is verified with the attending physician, .the following steps are initiated to complete documentation .clarify the order .(c) Written transfer orders .Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician, unless the order is unclear .