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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675363 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/28/2025 |
| NAME OF PROVIDER OR SUPPLIER Orchard Park Post Acute Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 721 Airport Dr Weslaco, TX 78596 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487</p> <p>Based on interview and record review the facility failed provide pharmaceutical services, including procedures that assure 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 medications.</p> <p>The facility failed to ensure nursing staff filled Resident #1's prescribed Acetaminophen-Codeine Tablet 300-30 MG.</p> <p>This failure could place residents at risk of not being adequately treated for pain and for receiving less than therapeutic benefits of their medication.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, dated 4/24/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included acquired absence of left leg below knee (a condition where an individual has had a surgical or traumatic removal, amputation, of part of the left leg below the knee joint), peripheral vascular disease (a condition that affects the blood vessels outside the heart and brain, primarily the arteries and veins, causing reduced blood flow to the limbs), type 2 diabetes mellitus with hyperglycemia (a chronic condition where the body either doesn't produce enough insulin or can't effectively use the insulin it does produce, leading to high blood sugar levels) and cellulitis of right lower limb (a bacterial skin infection that can cause redness, swelling, pain, and tenderness in the affected area.)</p> <p>Record review of Resident #1 care plan, dated 1/16/2025, revealed Resident #1 had risk for pain related to left below Knee Amputation. Resident #1 BIMS was 14.</p> <p>Record review of Resident #1's Medication Administration Record for February 2025, revealed Acetaminophen-Codeine Tablet 300-30 Milligrams, give 1 tablet by mouth every 6 hours for pain, and Resident #1 missed 3 doses (1 dose on 2/8/25 at 6:00 p.m. and 2 doses 2/9/25 at 12: a.m. and 6:00 a.m.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/23/2025 at 9:40 a.m., Resident #1 said he had in pain to his right lower extremity, he said he asked for his pain pill and LVN A went to give him a pill that did not look like his pain medication. Resident #1 said that he got an oval shape pill and said his Tylenol #3 was a round shape pill. Resident #1 said he took the medication because he was in pain. Resident #1 said he asked LVN A three times if that pill was the Tylenol #3 he usually took, the resident said LVN A said yes the three times he asked her. Resident #1 said on 2/10/25 he filed a grievance and spoke the administrator.</p> <p>During a phone interview on 4/24/2025 at 2:54 p.m., LVN A revealed Resident #1 did not have a filled prescription for Acetaminophen-Codeine Tablet 300-30 MG. She also stated the resident had an active order for this medication as of 1/18/2025 and she was unsure why it had not been filled. LVN A said that the morning nurse had called the physician assistant asking for a refill. LVN A said she got a Tylenol 500mg and gave it to Resident #1. LVN said she went back to reassess Resident #1 and he was sleeping. LVN A said she signed off on the medication record the Acetaminophen-Codeine Tablet 300-30 MG by mistake. LVN A said she forgot to add the order for Tylenol 500mg to Resident #1's electronic medical record. LVN A explained she was very familiar with the resident. LVN A said she had a standing order from the physician for Tylenol 500mg but forgot to add it and signed off on the electronic medication administration chart of Resident #1. LVN A said she did not have access to the cubex (emergency medication supply system) and she did not inform anyone that Resident #1 was out of the Acetaminophen-Codeine Tablet 300-30 MG. LVN A said that she was supposed to call the DON or ADON.</p> <p>During an interview on 4/24/25 at 3:40 p.m., the physician assistant said he was familiar with Resident #1's chronic pain. The Physician assistant first stated Resident #1's pain was 9 out of 10 on the scale of 1 to 10, would not have subsided with one acetaminophen 500 milligram tablet, after further discussion he said he was not sure if it would have been enough because Resident #1 regularly complained of pain without signs of distress.</p> <p>During a phone interview on 4/24/25 at 4:00 p.m., the pharmacist stated the facility received a new Tylenol #3 blister pack for Resident #1 on 2/9/25 at 12:00 p.m. The Pharmacist said he received a call from the Physician Assistant for a refill on Acetaminophen-Codeine Tablet 300-30 MG. The Pharmacist said the blister pack was delivered on 2/9/25.</p> <p>During an interview on 4/28/25 at 9:50 a.m., RN B said he worked on 2/8/25 in the morning shift. RN B said the resident was not in pain and he gave the last pill of the Acetaminophen-Codeine Tablet 300-30 MG at 12:00 p.m. RN C said he contacted the Physician Assistant to ask him for a refill. RN B said on 2/5/25 he called the physician assistant and told him Resident #1 was running low on the Acetaminophen-Codeine Tablet 300-30 MG. RN B said all nurses knew there was medication available on the cubex for an emergency. RN B said the blister packs had a blue line and when the medication was low to that blue line, that meant it was time to reorder the medication from the pharmacy.</p> <p>(continued on next page)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/28/2025 at 11:30 a.m., the DON said she was not aware about this incident with Resident #1 until 2/10/25 when Resident #1 filed a grievance. The DON said an investigation was initiated. The DON said nurses were trained on how to access the medications from the cubex and nurses knew to contact her or the ADON if the medication was not available on the cubex. The DON said the Physician assistant or the doctor had to call the pharmacy for the refill because this medication was a controlled medication, and the pharmacy needed a prescription for it. The DON said nurses did not know when the doctor was going to call the pharmacy, but she knew RN B called the physician assistant to informed him the resident was running low on the medication. The DON said the Acetaminophen-Codeine Tablet 300-30 MG was received at the facility on 2/9/25. The DON stated it was the facility's responsibility to ensure the resident had all of her ordered medications at the facility once the resident was transferred to long term care. The DON said when she spoke to the resident he was very upset because he felt LVN A lied about the medication he received.</p> <p>During an interview on 4/28/2025 at 12:00 p.m., the Administrator said Resident #1 spoke to her to file a grievance on 2/10/25. The Administrator said she started an investigation and spoke to LVN A and asked her what had happened, the Administrator said LVN A said to her she gave Resident #1 a Tylenol 500mg instead of Acetaminophen-Codeine Tablet 300-30 MG, because LVN A did not want for Resident #1 to get upset because it was not available. The Administrator said LVN A got a write up and was trained on how to access the cubex, medication administration and call supervisors when any medication was not available.</p> <p>Record review on 4/24/25 of Employee counseling report, dated 2/14/25, revealed LVN A statement documented I did tell patient it was a pain pill because i did not want to trigger an episode of patient getting upset and making a big issue of not having the narcotic available. I did not specify Tylenol just said pain pill.</p> <p>Record review of the facility's policy titled Controlled Substances Prescriptions, stated under section, Policy - before a controlled drug can be dispensed, the pharmacy must be in a receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribed. A char order is not equivalent to a prescription for controlled drugs. Therefore the prescriber issuing the chart order must also provide the pharmacist with a valid prescription. The written prescription may be faxed to the pharmacy for long-term care facility residents.</p> <p>Record review of the facility's policy titled Pain Management stated under section, Policy: The facility must ensure that pain management is provided to residents who require such services,, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487</p> <p>Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained for each resident that was complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for medication administration.</p> <p>The facility failed to ensure Resident #1's Medication Administration Record (MAR) reflected the administration of Tylenol (medication to treat pain) was accurately documented.</p> <p>This deficient practice could place residents at risk for less than therapeutic benefits and/or not receiving ordered medications.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, dated 4/24/25, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1 had diagnoses which included acquired absence of left leg below knee (a condition where an individual has had a surgical or traumatic removal, amputation, of part of the left leg below the knee joint), peripheral vascular disease (a condition that affects the blood vessels outside the heart and brain, primarily the arteries and veins, causing reduced blood flow to the limbs), type 2 diabetes mellitus with hyperglycemia (a chronic condition where the body either doesn't produce enough insulin or can't effectively use the insulin it does produce, leading to high blood sugar levels), cellulitis of right lower limb (a bacterial skin infection that can cause redness, swelling, pain, and tenderness in the affected area.)</p> <p>Record review of Resident #1's Physician Orders, dated 4/24/25, revealed an order for Acetaminophen-Codeine Tablet 300-30 Milligrams, give 1 tablet by mouth every 6 hours as needed for pain.</p> <p>Record review of Resident #1's Medication Administration Record for February 2025, revealed Acetaminophen-Codeine Tablet 300-30 Milligrams, give 1 tablet by mouth every 6 hours for pain. Resident #1 missed 3 doses (1 dose on 2/8/25 at 6:00 p.m. and 2 doses 2/9/25 at 12: a.m. and 6:00 a.m.</p> <p>Record review of Resident #1 care plan, dated 1/16/2025, revealed Resident #1 had risk for pain related to left Below Knee Amputation.</p> <p>During an interview on 4/23/2025 at 9:40 a.m., Resident #1 said he had pain to his right lower extremity, he said he asked for his pain pill, and LVN A went to give him a pill that did not look like his pain medication. Resident #1 said he took the medication because he was in pain. Resident #1 said he asked LVN A three times if that pill was the Tylenol #3 he usually took. The resident said LVN A said yes the three times he asked her. Resident #1 said on 2/10/25 he filed a grievance and spoke the administrator. Resident #1 said that the Tylenol 500 milligram that he took helped from a 9 on a scale from 1 to 10 to a 8.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a phone interview on 4/24/2025 at 2:54 p.m., LVN A revealed Resident #1 did not have a filled prescription for Acetaminophen-Codeine Tablet 300-30 MG. She also stated the resident had an active order for this medication as of 1/18/2025 and said she was unsure why it had not been filled. LVN A said that she got a Tylenol 500mg and gave it to Resident #1 LVN said that she went back to reassess Resident #1 and he was sleeping. LVN A said that she signed off on the medication record the Acetaminophen-Codeine Tablet 300-30 MG by mistake. LVN A said she forgot to add the order for Tylenol 500mg to Resident #1's electronic medical record. LVN A explained she was very familiar with the resident. LVN A said that she had a standing order from the physician for Tylenol 500mg but forgot to add it and signed off on the electronic medication administration chart of Resident #1. LVN A said that she did not had access to the cubex (emergency medication supply system) and that she did not inform anyone that Resident #1 was out of the Acetaminophen-Codeine Tablet 300-30 MG.</p> <p>During an interview on 4/24/25 at 3:40 pm, the physician assistant said that he was familiar with Resident #1 chronic pain. Physician assistant first stated Resident #1's pain 9 out of 10 on the scale 1 to 10 would not have subsided with one acetaminophen 500 milligram tablet, after further discussion he said that he was not sure if would have been enough because Resident #1 regularly complain of pain without signs of distress.</p> <p>During a phone interview on 4/24/25 at 4:00 pm the pharmacist verified that the facility received a new Tylenol #3 blister pack for Resident #1 on 2/9/25 at 12:00 pm. Pharmacist said that he received a call from Physician Assistant for a refill on Acetaminophen-Codeine Tablet 300-30 MG. pharmacist said the blister pack was delivered on 2/9/25.</p> <p>During an interview on 4/28/2025 at 11:30 a.m., the DON said she was not aware about this incident with Resident #1 until 2/10/25 when Resident #1 filed a grievance. DON said that an investigation was initiated. DON said that nurses were trained on how to access the medications from the cubex and nurses knew to contact her or the ADON if the medication was not available on the cubex. DON said that the Physician assistant or the doctor had to call the pharmacy for the refill because this medication was a controlled medication, and the pharmacy needed a prescription for it. DON said that nurses did not know when the doctor was going to call the pharmacy, but she knew RN B called the physician assistant to informed him resident was running low on the medication. DON said that the Acetaminophen-Codeine Tablet 300-30 MG was received at the facility on 2/9/25. The DON agreed that it was the facility's responsibility to ensure the resident had all of her ordered medications at the facility once the resident was transferred to long term care. DON said that when she spoke to resident he was very upset because he felt LVN A lied about the medication he got. The DON said LVN A should have documented giving the Tylenol 500mg on the electronic medication record. LVN A said that she forgot to input the order on Resident#1's medical administration record.</p> <p>During an interview on 4/28/2025 at 12:00 p.m. with the Administrator said that Resident #1 spoke to her to file a grievance on 2/10/25. The administrator said that she started an investigation and spoke to LVN A and asked her what had happened, the administrator said that LVN A said to her that she gave Resident #1 a Tylenol 500mg instead of Acetaminophen-Codeine Tablet 300-30 MG because LVN A did not wanted for Resident #1 to get upset because was not available. The administrator said that LVN A got a write up and was trained on how to access the cubex, medication administration and call supervisors when any medication was not available.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review on 4/24/25 of Employee counseling report dated 2/14/25 revealed LVN A statement I did tell patient it was a pain pill because i did not want to trigger an episode of patient getting upset and making a big issue of not having the narcotic available. I did not specify Tylenol just said pain pill.</p> <p>Record review of the facility's policy titled Medication Administration, revealed: Medications are administered by a licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination of infection. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR.</p> |