

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Sunflower Park Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1803 Highway 243 East Kaufman, TX 75142	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</p> <p>Based interviews and record review, the facility failed to ensure each resident was free from abuse, neglect, exploitation, and misappropriation of resident property for 1 of 3 residents (Resident #1), reviewed for drug diversion .</p> <p>The facility failed to prevent the misappropriation of Resident #1's Ondansetron. (Ondansetron is commonly used to prevent nausea and vomiting).</p> <p>This failure could place residents at risk for not receiving their prescribed medications.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, dated 9/30/21, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Contractures (In pathology, a contracture is a shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), Dysphagia (Difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage) and Dementia (a broad term describing the loss of cognitive function, impacting thinking, memory, and reasoning, and significantly affecting daily life).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 11/23/24, documented Resident #1 BIMS score was 04, which indicated severe cognitive impairment. Resident #1 required extensive assistance with her ADLs .</p> <p>Record review of Resident #1's, undated, care plan documented the resident was at risk for nausea regarding her medications. Ondansetron was used for nausea prevention. The care plan documented, Monitor for altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus , respiratory distress, sedation, urinary retention. Observe for adverse reactions with every interaction with the resident.</p> <p>Record review of Resident #1's order for Ondansetron. Order dated 2/11/2022 for Ondansetron 8 milligram, Give 1 tablet by mouth as needed for nausea and vomiting.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility provider investigation report, dated 11/22/2024, revealed CMA A's text messages were brought to the facility by a community member that was involved with CMA A. The text messages read, on July 5th 2024 [NAME] if I get Hydros yall want them? .I've got two 10's rn .Okay Ill see what I can do. If I ever get any, yall want them right. Even if 5s or 10s? .Okay bet .I got two hydros rn .I only got 2 rn I will get some more later. The text messages were screenshots provided to the facility with only CMA A's replies visible the replies from the unknown person CMA A was talking to was redacted with a white line. The contact entry for this text conversation was the name of CMA A. The same community member, unknown name or number also provided a screenshot of Resident #1's blister pack of Ondansetron from the facility. The community member said CMA A had this blister pack in her home. The Investigation report documented an audit was completed of medications in the facility and all medications were accounted for. The investigation report documented the alleged perpetrator, CMA A, admitted to the allegations but nowhere in her written statement did she admit to the allegations. CMA in her written statement said that the allegations were untrue and the community member was mad at her regarding outside facility drama. However, the community member had a picture of Resident #1's blister pack.</p> <p>During an interview on 4/15/25 at 8:30 a.m., the Regional Compliance Nurse said there was an incident regarding drug diversion in the facility around November of 2024. She said a member of the community, unknown name, brought a picture from her phone that showed Resident #1's blister pack of Ondansetron and said she had it at her home. She said Ondansetron controls nausea and vomiting. She said supposedly CMA A stole this medication from Resident #1 to give to her pregnant roommate. She said the community member was that pregnant roommate. She said they could only assume the community member and CMA A had a falling out and the roommate decided to tell on what CMA A had been doing. The community member also had screenshots of texts where CMA A was going to try to get Xanax and had already had in her possession hydros. She said some of these text screenshots dated back to July 2024. She said they did not know for sure if these hydros were coming from the facility or from somewhere else in the community. She only admitted to taking the Ondansetron. She said all residents afterwards were assessed for pain and an audit on all the drugs in the facility was accounted for. She said residents who had pain said their pain was under control. She said in a hypothetical situation if a CMA was taking 1 of 3 hydrocodone from a resident daily they would not know about the drug diversion unless the resident complained or the thief was stealing more than just daily medications. She said their audit and count was never off because CMA A was likely only stealing small amounts of medications. She said CMA A was terminated after this incident as she admitted to taking the Ondanesteron when confronted with the screenshot . She said the current administrator and director of nurses were not at the facility during this incident and would not have any additional information to provide. She said she took part of this investigation and was able to provide all the details of the investigation. She stated Resident #1 was no longer a resident at the facility.</p> <p>During an interview on 4/16/25 at 2:16 p.m., the Director of Nurses said it was against facility policy for staff to take resident's medications out of the facility. She said this act was called a drug diversion. She said the resident was at risk for vomiting, nausea, and dehydration when CMA A took the Ondansetron out of the facility.</p> <p>During an interview on 4/16/25 at 2:40 p.m., the Administrator said it was against facility policy for staff to steal medications from residents. She said a drug diversion was a reportable incident. She said the employee no longer worked for the facility. She said the resident could be placed at risk of harm if they had their medications stolen.</p> <p>(continued on next page)</p>		

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