STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675431	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Oak Health and Rehabilitation Center	101 Reese Dr Red Oak, TX 75154

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observations, interviews, and record review, the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 8 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure MA A secured Resident 1's medication when she left Resident #1's medications on her bedside table for her to self-administer and did not ensure the resident took her medication. This failure could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion. Findings included: Record review of Resident #1's face sheet reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (Stroke a disruption of the blood flow to the brain causing part of the brain to die), dehydration, post-traumatic stress syndrome, unspecified psychosis, and anxiety disorder. Record review of Resident #1's care plan dated 10/17/2023 reflected she was resistive to care related to episodes of refusing medication. Her goal was for her to cooperate with taking medications as per medical doctors orders through next review date. Interventions were If Resident #1 resist taking medications leave and return 5-10 minutes later and try again. If Resident #1 continues to refuse to take medications notify medical doctor and responsible party and document in chart. Record review of Resident #1's Quarterly MDS assessment, dated 10/24/2024, reflected she had a BIMS score of 15, which indicated she was cognitively intact. Resident #1 was coded Substantial Maximal Assistance with her ADLs (dressing, bathing, grooming, and toileting) indicating the helper or staff performed more than half the effort for the resident to complete the task . (continued on next page)

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 11/20/24 at 10:30 AM Resident #1 stated she had no concerns with abuse or neglect and felt safe there. She stated she had a call light and staff get to her as soon as they could. She stated she received her medication as scheduled. Observed 2 clear oblong pills laying on the bedside table, Resident #1 stated they were fish oil pills. Resident #1 stated staff leave her medication, peanut butter crackers, and water on the bedside table and do not watch her take her medications. She stated MA A administered her morning medications. In an interview on 11/20/24 at 10:40 AM MA A stated she has worked at the facility for 2 years. She stated she was delegated to pass medication. She stated when passing medication she matched the name to the medication, matched the medication dosage, and read the directions on the medication. She provided the medication with water, watched the resident take the medication, and checked off the medication on the MAR. She stated if the resident refused, she must notify the nurse. She stated she administered Resident #1's medication this morning and watched her take her medication. She stated she administered the medication to Resident #1 and walked back to the medication cart to document it in the MAR. As she was documenting she was overseeing the resident, she thought the resident had taken all her medications, so she moved on to the next resident . MA A stated she was responsible for making sure residents swallowed and took their medications. She stated leaving medications at the bedside may result in the resident not taking her medications. In an interview on 11/20/24 at 11:47AM the ADM stated staff were not supposed to leave any medications in the room. He stated the staff were supposed to stay with the resident and make sure the medications were swallowed. The ADM stated staff were educated on the medication administration process by the DON, the ADON, and the unit mangers. The ADM stated the risk for leaving medications on the resident's bedside table and not ensuring residents were taking medications could result in subtherapeutic effects of medications, missed medications, or a demented resident could wonder in the room and take the medications that were not theirs. In an interview on 11/20/24 at 12:09 PM the DON stated MA A never should leave medications on beside tables. She stated she has recently educated all nurses and medication aides on medication pass step by step instructions. She stated she was responsible for educating the staff on the medication pass policy. The DON stated all staff were responsible for passing medications and were checked off visually on skills annually by the DON. She stated negative effects included the resident may not take their medications. Record review of facility Inservice titled Medication Pass Process dated 11/01/2024 reflected staff were never to leave the medications in the room for the resident to take later. The in-service was signed by MA A. Record review of facility policy titled Administering Medications dated 2001 and Revised December 2012 reflected, Medications shall be administered in a safe and timely manner, and as prescribed. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.