| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675438 | A. Building<br>B. Wing | 05/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakeshore Village Nursing and Rehabilitation | 2320 Lake Shore Dr<br>Waco, TX 76708 |

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) |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073<br><br>Based on observation, interview, and record review, the facility failed to 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 and to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 2 of 7 residents (Residents #2 and 3) reviewed for pharmaceutical services.<br><br>1. The facility failed to administer medications (dicyclomine, Eliquis, Zoloft, lactulose, levetiracetam, and enalapril maleate) to Resident #2 on time on 05/09/24, 05/10/24, 05/11/24, 05/12/24, 05/13/24, 05/14/24, and 05/15/24.<br><br>2. The facility failed to implement their controlled substances policy when they discovered a bottle of oxycodone in Resident #3's possession on 01/19/24 without an order in place.<br><br>These failures placed residents at risk of not receiving medication therapies, overdose, and drug diversion.<br><br>Findings included:<br><br>1.<br><br>Review of the undated face sheet for Resident #2 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included colostomy status (surgery to create an opening in the colon to eliminate solid waste), chronic obstructive pulmonary disease (disease characterized by persistent respiratory symptoms like progressive breathlessness and cough), Crohn's disease of large intestine (chronic disease that causes inflammation and irritation in your digestive tract), generalized abdominal pain, need for assistance with personal care, muscle weakness, lack of coordination, convulsions, depression, chronic idiopathic constipation (constipation with no known cause), schizoaffective disorder, seizures, hypertension (high blood pressure).<br><br>Review of the quarterly MDS for Resident #2 dated 02/07/24 reflected a BIMS score of 15, indicating intact cognition.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the care plan for Resident #2 dated 10/25/23 reflected the following: [Resident #2] has a potential for side effects r/t use of antidepressant medication. The care plan dated 12/12/23 reflected [Resident #2] has a potential for pain r/t GERD, PE [blood clot that blocks a lung artery], Arthritis, Chronic Physical Disability, neuropathy. The care plan dated 12/12/23 reflected, [Resident #2] has impaired neurological status r/t dx of seizure disorder vs. pseudo seizures (seizures that do not involve changes to the electrical impulses in the brain and usually have a psychological cause). anticonvulsant, antianxiety.<br><br>Review on 05/16/24 of physician's orders for Resident #2 reflected the following:<br><br>Dicyclomine HCl Tablet 20 MG Give 1 tablet by mouth four times a day for ABD pain; start date 05/08/24;<br><br>Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for PE; start date 01/05/24;<br><br>Zoloft Oral Tablet 50 MG (Sertraline HCl) Give 2 tablet by mouth in the morning related to DEPRESSION, UNSPECIFIED (F32.A); SCHIZOAFFECTIVE DISORDER, UNSPECIFIED (F25.9) Give 100mg/po/daily for mood; start date 04/15/24;<br><br>Lactulose Oral Solution 10 GM/15ML (Lactulose) Give 30 ml by mouth two times a day for constipation; start date 05/08/24;<br><br>levETIRAcetam Oral Tablet 1000 MG (Levetiracetam) Give 1500 mg by mouth two times a day for seizures take 1.5 tablets (1,500mg) by mouth twice daily; start date 12/23/23;<br><br>Enalapril Maleate Oral Tablet 20 MG (Enalapril Maleate) Give 1 tablet by mouth in the morning for Hypertension hold for SBP<100 DBP <60 HR<60; start date 01/05/24.<br><br>Review of the April 2024 MAR for Resident #3 reflected the following administration times:<br><br>05/09/24 Zoloft scheduled at 08:00 AM; administered at 09:57;<br><br>05/09/24 Lactulose scheduled at 08:00 AM; administered at 09:57;<br><br>05/09/24 Dicyclomine scheduled at 08:00 AM; administered at 09:57 (pain scale at 0 meaning no pain);<br><br>05/09/24 Levitiracetam scheduled at 08:00 AM; administered at 09:57;<br><br>05/09/24 Enlapril Maleate scheduled at 08:00 AM; administered at 09:57 (BP was at baseline 149/79);<br><br>05/09/24 Dicyclomine scheduled at 04:00 PM; administered at 05:36 PM (pain scale at 0 meaning no pain);<br><br>05/10/24 Eliquis scheduled at 06:00 PM; administered at 07:12 PM;<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 05/11/24 Enlapril Maleate scheduled at 08:00 AM; administered at 10:36 AM (BP was at baseline 134/82);<br><br>05/11/24 Dicyclomine scheduled at 12:00 PM; administered at 01:13 PM (pain scale at 0 meaning no pain);<br><br>05/12/24 Dicyclomine scheduled at 04:00 PM; administered at 05:57 PM (pain scale at 0 meaning no pain);<br><br>05/13/24 Dicyclomine scheduled at 04:00 PM; administered at 05:13 PM (pain scale at 0 meaning no pain);<br><br>05/14/24 05/09/24 Zoloft scheduled at 08:00 AM; administered at 09:13;<br><br>05/14/24 Lactulose scheduled at 08:00 AM; administered at 09:13;<br><br>05/14/24 Dicyclomine scheduled at 08:00 AM; administered at 09:13 (pain scale at 0 meaning no pain);<br><br>05/14/24 Levitiracetam scheduled at 08:00 AM; administered at 09:13;<br><br>05/14/24 Enlapril Maleate scheduled at 08:00 AM; administered at 09:13 (BP was at baseline 139/80);<br><br>05/15/24 Dicyclomine scheduled at 12:00 PM; administered at 02:04 PM (pain scale at 0 meaning no pain).<br><br>During observation and interview on 05/16/24 at 11:42 AM, Resident #2 was lying in his bed resting but sat up and wanted to be interviewed. He stated he often received his medication late. He stated he did not know how late they were, but it was often over an hour. He stated the late medications were in the morning and the afternoon. He stated the late medications he remembered were seizure medication, blood pressure medication, lactulose, and he was not sure what else. He stated he did not know if there had been a negative effect of the late medications, but he did not like it.<br><br>During an interview on 05/16/24 at 06:25 PM MA B stated she administered medication to 40 residents starting at 08:00 AM until 08:00 PM. She stated most of her administrations were in the morning and at night, but she had a few during the middle of the day. MA B stated the daytime medications usually start around noon and are complete by 01:55 PM or 02:00 PM. MA B stated she always administered medications to Resident #2 when she worked. MA B stated she gave his dicyclomine when she gave his Eliquis. She then stated she gave the dicyclomine at 04:00 PM but did not document she gave it until she documented the Eliquis at 05:30 PM or 06:00 PM. MA B stated Resident #2 had never complained about giving late medications, and she always tried to be fast.<br><br>2.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the undated face sheet for Resident #3 reflected a admitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses included chronic pain, major depressive disorder, chronic gout (a type of arthritis that causes inflammation in the joints), osteoarthritis (breakdown of joint cartilage and underlying bone), nondisplaced oblique fracture of shaft of right fibula (lower leg bone fractured diagonally to its axis but remained aligned), need for assistance with personal care, and cognitive communication deficit (problem communicating caused by cognitive impairment).<br><br>Review of the admission MDS for Resident #3 dated 01/26/24 reflected she received opioid pain medication seven days of the seven-day lookback period.<br><br>Review of the care plan for Resident #3 dated 02/02/24 reflected the following: [Resident #3] has a potential for pain r/t OA, Gout, Fracture. Resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Medicate as ordered.<br><br>Review of progress notes for Resident #3 from reflected the following notes documented by LVN B:<br><br>01/19/24 06:00 PM Oxycodone APAP 5-325 pill bottle found in her purse, patient admitted to just taking a pill at [05:45 PM], notified MD to obtain an order for this medication.<br><br>01/19/24 06:05 PM MD order to continue with Norco and Lyrica order at this time, Oxy has been placed in nurses lock box.<br><br>Review of the inventory of personal effects for Resident #3 dated 01/19/24 reflected no mention of the Oxycodone confiscated from her by LVN B on 01/19/24.<br><br>Review of physician orders for Resident #3 from January 2024 to February 2024 reflected no order for Oxycodone.<br><br>Review of the discharge summary for Resident #3 reflected no mention of the bottle of Oxycodone confiscated from her by LVN B on 01/19/24.<br><br>An interview with Resident #3 by telephone was attempted on 05/16/24 at 12:24 PM and at 07:47 PM. Both times the line went straight to voicemail. A voicemail was left both times.<br><br>During an interview on 05/16/24 at 03:19 PM, LVN B stated she went into Resident #3's room on her first day in the facility, 01/19/24, to talk to her about medications, and Resident #3 was putting a bottle of Oxycodone back in her purse. LVN B stated she obtained the bottle from the resident, locked it on the medication cart, and contact the physician for an order. LVN B stated she learned from the physician and from looking at Resident #3's discharge orders that she was not prescribed Oxycodone but was prescribed Norco, and there was already an order in place for that medication. LVN B stated the bottle of Oxycodone was pulled from the cart and given to the DON, and LVN B heard the pills were destroyed. LVN B stated she could not remember if it was her that pulled the bottle of pills from the cart and gave them to the DON or not. LVN B stated she thought she remembered that the bottle was prescribed to Resident #3 but was not entirely sure. LVN B stated the correct procedure for that situation was to lock the pills up, report their presence to the DON, and the DON either locked them into a lockbox in the medication room until the resident they belonged to was discharged or destroyed the medications .<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 05/16/24 at 05:00 PM, the DON stated the only people who had medications administered late within policy were people who were out at an appointment and came back late. She stated they had talked about shifting to a liberalized medication administration time policy, but currently the policy on timely medication administration was within one hour before or one hour after the scheduled time. The DON stated anything that had to be timed specifically such as a medication given four times a day or with meals should have been administered on time. The DON stated if the medication aides could not administer medications on time, they should have notified the charge nurse who would then contact the physician to make sure there were no adverse effects. She stated she monitored for compliance with medication administration time by trusting that her medication aides and nurses would report if medications were administered late. She stated a possible negative impact of late medications could be from feelings of anxiety all the way to a resident might not receive the greatest benefit of medication therapy. The DON stated LVN B had told her about the Oxycodone that was confiscated from Resident #3 that afternoon, but she had not heard about the confiscated Oxycodone prior to that. She stated the procedure should have been to lock the narcotics up and notify the DON immediately so she could figure out what to do with them. The DON stated if the medications were prescribed to the resident who had them, they would be given to the family or held under double lock until the resident discharged . The DON stated if the medications were not prescribed, then they would be considered illicit drugs, and law enforcement would probably be notified, and the pills given to law enforcement. The DON stated she had never encountered that situation before. The DON stated she had looked for the bottle of Oxycodone after LVN B told her about the situation that afternoon, but she had not found the pills. She stated she had checked the drug destruction records and found no documentation of the Oxycodone. She stated that she needed to investigate further, but it was possible the missing pills would need to be treated like a drug diversion. She stated the facility staff would need to look everywhere for them before determining they could not be found. She stated the facility policy/procedure was not followed for Resident #3's Oxycodone, because there was no tracking of where the pills had gone, and she stated she was concerned by that. The DON stated she oversees the drug destruction and storage of narcotics process at the facility, and she had never had any problems prior to this issue that would require monitoring of the system. She stated a potential impact of the failure was drug diversion or overdose, depending on the situation. She stated the facility did not have policy specifically for the timing of medication administration. She stated the drug diversion policy was best addressed by the facility's policy on misappropriation of property.<br><br>Review of facility policy dated April 2021 and titled Identifying exploitation, theft, and misappropriation of resident property reflected the following:<br><br>As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property.<br><br>Examples of misappropriation of resident property include:<br><br>F. Drug diversion (taking resident's medication).<br><br>6. Staff and providers are expected to report on suspected exploitation, theft, or misappropriation resident property.<br><br>7. The QA committee reviews and creates plans of action to address quality deficiencies that may lead to exploitation, theft, or misappropriation of resident property. |