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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675468 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/07/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Hico Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE: 712 Railroad Ave, Hico, TX 76457 | |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949<br><br>Based on interview and record review, the facility failed to immediately notify the resident's representative(s) when there was a significant change in the resident's physical status for one (Resident #1) of five residents reviewed for changes in condition, in that:<br><br>The facility failed to notify Resident #1's RP (FM) after she experienced a fall on 01/14/24 at 5:47 am which resulted in the resident sustaining a bump to her head and a complaint of pain to her hip and leg.<br><br>This failure placed residents at risk of a delay in treatment and their responsible party not being informed and involved in care decisions.<br><br>Findings included:<br><br>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including syncope (fainting due to a decrease in blood flow to the brain), glaucoma (a condition where the eye's optic nerve is damaged), and abnormal brain scan.<br><br>Review of Resident #1's Resident Information sheet in her admission packet, dated 12/13/23, reflected FM as her emergency contact and responsibly party.<br><br>Review of Resident #1's admission MDS assessment, dated 12/20/23, reflected a BIMS (assessment of cognitive function) was not conducted. It further revealed Resident #1 received no intervention for pain. Review further revealed no falls since admission or prior to admission. Further review revealed Resident #1 required setup or cleanup assistance with toileting hygiene.<br><br>Review of Resident #1's admission care plan, dated 01/15/24, reflected she had an actual fall with no serious injury due to unsteady gait with an intervention of having a PT consult for strength and mobility.<br><br>Review of the facility 01/17/24 self-report revealed Resident #1 suffered a fall on 01/14/24 at 5:47 am.<br><br>Review of Resident #1's January 2024 progress notes revealed no progress note related to the fall.<br><br>(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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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's incident report, dated 01/14/24 7:29 am, reflected the following:<br><br>Resident #1 was self-transferring to the bathroom, her tri-walker folded causing Resident #1 to miss the toilet, urinate on the floor leading to slipping and falling per patient report The report further revealed no injuries were observed at the time of the fall. The report section titled injuries reflected injury to the left shoulder and other (describe) with no further description.<br><br>During an interview on 02/24/24 at 12:36 pm LVN A stated that she answered a call light for the room next to Resident #1 and that resident heard a fall in the con-joined bathroom. LVN A found Resident #1 had fallen, urine was on the floor and her walker was folded against the door. LVN A stated that the resident had a hematoma (swollen knot) to her right forehead and complained of pain in her left arm. She stated the internet was down, so she could not see Resident #1's face sheet to notify the FM. She asked if there were printed face sheets that she could reference and was told there were none. She texted the DON and got the hospice phone number and notified hospice. Hospice stated they would notify the FM. She initiated neuro checks on paper due to lack of access to EHR.<br><br>During an interview and record review on 02/24/24 at 10:47 am with the FM she stated the facility did not notify her Resident #1 fell and she found out on 01/14/24 around 2:00 pm when she arrived to visit Resident #1 at the facility and crossed paths with a hospice nurse. The FM stated that Resident #1 was guarding her left arm and told her it hurt because she had fallen. The FM then shared a screenshot of her phone log for 01/14/24 which revealed no missed or incoming calls from the facility on 01/14/24. The FM stated that she would have requested Resident #1 be sent to the emergency room for evaluation if she had been notified.<br><br>Review of Facility Provider Investigation Report dated 01/26/24 revealed LVN A's assessment at the time of the fall was Resident #1 had a bump on her head but did not complain of pain until later in the day on 01/14/24. It further revealed that the FM was notified. It further revealed that Resident #1 did not use the call light, self-ambulated to the restroom with folding walker and fell on the floor of her room; Resident #1 yelled for help and LVN A found Resident #1 on the floor and urine was on the floor. Immediate assessment revealed a bump on Resident #1's head and said she did not complain of pain at the time. It stated later in the day the resident complained of pain in her leg and hip; x-rays were ordered for 01/15/24 but were delayed by weather and done 01/16/24.<br><br>During an interview on 02/25/24 at 10:15 am with the DON, she stated not notifying families may affect families psychologically that may cause anxiety or depression.<br><br>During an interview on 02/25/24 at 1:15 pm with the ADM, he stated the harm of not notifying families of conditions may cause anxiety.<br><br>Review of the undated facility policy titled Notification of Changes reflected that the facility must promptly notify the resident's family member or legal guardian when there is an accident or need to alter treatment. |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46565<br><br>Based on observation, interview and record review, the facility failed to ensure that residents are free from abuse, neglect, misappropriation of resident property, and exploitation; the facility failed to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress for two (Resident #1, Resident #2) of five residents reviewed for neglect.<br><br>The facility failed to:<br><br>1. ensure Resident #1's pain in her arm and hip was addressed after a fall on [DATE] by providing her prescribed tramadol which had run out and hospice nurse reported constant pain in left forearm<br><br>2. ensure Resident #1's neuro checks were completed and documented after a fall [DATE] in which she hit her head and displayed an increase in confusion<br><br>3. ensure Resident #1's x-rays were performed in a timely manner after a fall on [DATE] after which she complained of pain and x-rays were not performed until [DATE]<br><br>4. ensure Resident #2's pain was addressed by providing his prescribed hydrocodone for 3 days while it had run out leading to pain that went as high as a 9, especially at night causing inability to sleep, but averaged at a 6 for the duration of this time when his medication was unavailable<br><br>An immediate jeopardy situation was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:15 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with a severity of potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>These failures led to uncontrolled pain and unidentified injuries and placed all residents at risk of not having their needs met to reach their highest practicable mental, physical and psycho-social wellbeing.<br><br>Findings included:<br><br>Resident #1<br><br>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including syncope (fainting due to a decrease in blood flow to the brain), glaucoma (a condition where the eye's optic nerve is damaged), and abnormal brain scan.<br><br>Review of Resident #1's [DATE] orders revealed the following:<br><br>*Portable X-ray to left upper extremity. Maybe fractured after a fall. C/o lots of pain, dated [DATE].<br><br>(continued on next page) |

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

*X-ray of left lower extremity(hip/pelvis) left upper extremity shoulder, left ribs dated [DATE].

*Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 4 hours as needed for pain dated [DATE].

*Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every morning and at bedtime for Pain related to NEOPLASM (cancer) OF UNSPECIFIED BEHAVIOR OF BRAIN dated [DATE].

Review of Resident #1's Resident Information sheet in her admission packet, dated [DATE], reflected the FM as her emergency contact and responsibly party.

Review of Resident #1's admission MDS assessment, dated [DATE], reflected a BIMS (assessment of cognitive function) was not conducted. It further revealed Resident #1 received no intervention for pain. Review further revealed no falls since admission or prior to admission. Further review revealed Resident #1 required setup or cleanup assistance with toileting hygiene.

Review of Resident #1's undated care plan, reflected it had a focus of admission to hospice with a goal of keeping Resident #1 as comfortable as possible and intervention of administer pain medications as ordered and assess for verbal and non-verbal signs/symptoms of pain or discomfort all initiated on [DATE]. Further review revealed the care plan had a focus dated [DATE], and reflected she had an actual fall with no serious injury due to unsteady gait with an intervention of having a PT consult for strength and mobility. An intervention of For no apparent acute injury, determine and address causative factors of the fall and it was initiated [DATE].

Review of the facility self-report revealed Resident #1 suffered a fall on [DATE] at 5:47 am.

Review of Resident #1's [DATE] progress notes revealed no progress note related to the fall on [DATE].

Review of Resident #1's hospice progress by HRN A note dated [DATE] (no time on note) revealed Resident #1 had a fall per RN A and was sitting in her wheelchair when hospice arrived. The note reflected Resident #1 complained of pain to the left upper arm, and a hematoma (swollen knot) was noted to the left side of her head and she had a sore upper arm with continuous pain to arm. Resident #1 needed refills of tramadol and lorazepam and it was called in to the facility pharmacy. The note reflected the hospice doctor requested an order for a portable x-ray to the left upper arm.

Review of Resident #1's entire EHR from her admission in [DATE] through her discharge in [DATE] revealed no neuro checks documented in any portion (including assessments, progress notes, and miscellaneous).

Review of Resident #1's progress notes, from [DATE] through [DATE], revealed the following:

*[DATE] 11:38 am: tramadol HCl Oral Tablet 50 MG, Med not available Hospice nurse will have med delivered by RN A.

*[DATE] 9:20 pm: tramadol HCl Oral Tablet 50 MG, Medication unavailable; Hospice notified [DATE] at 6:00 am by LVN A.

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | *[DATE] 6:03 am: tramadol HCl Oral Tablet 50 MG, Medication unavailable by LVN A.<br><br>Review of Resident #1's [DATE] MAR revealed her tramadol was administered [DATE] at 8:17 pm; missing her scheduled bedtime dose [DATE], morning dose [DATE] and PRN doses after her fall.<br><br>Review of Resident #1's x-ray of the left hip dated [DATE] revealed a possible fracture through the neck of the left femur (long bone in the leg) and recommended CT scan to correlate findings.<br><br>During an observation on [DATE] at 5:10 pm with Resident #1 at a new facility, revealed she looked like she was trying to stay very still. She was not able to answer questions, and was tucked under blankets with pillows and padding around her.<br><br>During an interview on [DATE] at 5:15 pm with the New Facility ADM, she stated Resident #1 was comfortable when she did not move, but when staff had to reposition her or change her she was in excruciating pain and would yell out with tears in her eyes. New Facility was pre-medicating Resident #1 with pain medicine before having to reposition her but she was still in pain. The New Facility ADM stated that Resident #1 admitted with severe pain in her left hip and blanching and redness to her skin from a pressure injury to her coccyx.<br><br>During an interview on [DATE] at 12:36 pm LVN A stated that she answered a call light for the room next to Resident #1 and that resident heard a fall in the con-joined bathroom. LVN A found Resident #1 had fallen, urine was on the floor and her walker was folded against the door. She stated Resident #1 had a hematoma (swollen knot) to her right forehead and pain in her left arm. She stated the internet was down, so she could not see Resident #1's face sheet to notify the FM. She texted the DON that Resident #1 had an unwitnessed fall and a red raised area to the right front side of the head and complained of pain in her left shoulder with vitals bp ,d+[DATE], pulse 102, resp 18, O2 at 87 on room air (applied oxygen) and a temperature of 97.7. degrees Fahrenheit. The DON got the hospice provider's phone number and hospice was notified. Hospice stated they would notify the FM. LVN A initiated neuro checks on paper due to lack of access to the EHR. LVN A stated she administered the last tramadol to Resident #1 shortly after her fall and informed hospice that Resident #1 needed tramadol and lorazepam. LVN A left the paper to continue the neuro checks with RN A when LVN A's shift ended. RN A took over care of Resident #1 on [DATE] (day of fall) at 7:00 am.<br><br>During an interview on [DATE] at 11:30 am with RN A she stated that she administered tramadol to Resident #1 on the day of her fall ([DATE]) when prompted she said she would have put it in the MAR. She stated she entered x-ray that hospice doctor ordered on [DATE] and then called the x-ray company. RN A then stated that she was not working the day that the x-ray was ordered and that the DON called the x-ray company . RN A stated she did not remember if she performed neuro checks or not on Resident #1. RN A cared for Resident #1 on [DATE] - [DATE] (discharge). RN A was not able to answer all questions asked and when she answered she gave conflicting information multiple times.<br><br>Record review of Resident #1's [DATE] vitals revealed no blood pressure, respiratory rate, temperature, nor pulse entered by RN A on [DATE], [DATE], nor [DATE] (dates neuro checks should have been done).<br><br>Record review of Resident #1's discharge summary dated [DATE] at 2:28 pm created by RN A revealed Resident #1 was discharged to another facility on [DATE] at 2:54 pm.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident #1's [DATE] vitals revealed the following pain assessments:<br><br>-[DATE] 12:00 am level 4 entered by DON<br><br>-[DATE] 5:46 am level 4 entered by LVN A<br><br>-[DATE] 7:00 am level 3 entered by LVN A<br><br>-[DATE] 7:32 am level 3 entered by LVN A<br><br>-[DATE] 8:31 am level 3 entered by LVN A<br><br>-[DATE] 11:38 am level 4 entered by RN A<br><br>-[DATE] 9:30 pm level 3 entered by LVN A<br><br>-[DATE] 1:36 am level 3 entered by LVN A<br><br>-[DATE] 8:17 pm level 7 entered by LVN F<br><br>-[DATE] 5:30 am level 3 entered by LVN A<br><br>-[DATE] 8:13 am level 0 entered by Former Employee<br><br>-[DATE] 9:25 pm level 8 entered by LVN F<br><br>-[DATE] 8:56 am level 6 entered by RN A<br><br>-[DATE] 9:00 am level 4 entered by the DON<br><br>Record review of Resident #1's 24- hour report for [DATE]-[DATE] revealed:<br><br>-[DATE] - no entry for Resident #1.<br><br>-[DATE] - Resident #1 showing increased confusion, no record of a fall entered by LVN A<br><br>-[DATE] - X-ray will be done tomorrow ([DATE]) for x-ray to left hip; fall on [DATE], x-ray ordered, and no tramadol entered by LVN F.<br><br>-[DATE] - blank, all entries reflected to see [DATE] entered by LVN F.<br><br>-[DATE] - Resident #1 7a-3p shift - neuro's, left at 3:00 pm, person who documented this did not fill out his/her name.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on [DATE] at 5:50 pm the DON she stated she was not at work [DATE], the day Resident #1 fell . She then stated the results from Resident #1's post-fall x-rays (of her left hip, ribs, and shoulder but not forearm) were reported to the facility on [DATE] (same day as the x-rays were done). The DON stated the internet was down [DATE] due to high winds and the facility was notified that the x-ray company would not be able to do the x-ray until [DATE] due to the weather. The DON stated that because the internet was down, Resident #1's neuro checks were written on paper. She was unable to produce the paper and stated it was lost and she could not find the paper with the neuro checks on it. She stated the neuro checks were never entered into the EHR. She said she would usually collect information documented on paper and ensure it was entered into the EHR. She stated that tramadol was not in the hospice comfort kit and medication for hospice residents could not be pulled from the nexsys supply.<br><br>During an interview on [DATE] at 10:47 am with the FM she stated she was not notified that the x-rays were not going to be done until [DATE] nor was she told she could send Resident #1 to the hospital for immediate evaluation. If she had been told there was going to be a 2-day delay for x-rays she would have sent Resident #1 to the hospital. The FM stated Resident #1 was guarding her left arm and stated she was in pain at 2:00 pm on [DATE] when she visited.<br><br>During an interview on [DATE] at 11:35 am the Hospice Nurse stated that when she saw Resident #1 after the fall, she had a complete decline in function that was directly attributed to the fall. She stated she re-ordered pain medication for Resident #1 before the weekend of [DATE]-14th, so Resident #1 would not run out. She did not know why the medication did not arrive before [DATE]. She stated Resident #1 was in constant pain from the time of the fall and including the time she was admitted to the new facility. She said the new facility pre-medicated Resident #1 prior to moving her, but Resident #1 was still in pain unless she lies still.<br><br>Resident #2<br><br>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including acute post-procedural pain, spinal stenosis (narrowing of the spine), gout, and repeated falls.<br><br>Record review of Resident #2's annual MDS dated [DATE] revealed Resident #2 had a BIMS of 15, which indicated he was cognitively intact. It further revealed that Resident #2 had experience pain or hurting frequently in the past 5 days and that he had not experienced any falls since admission.<br><br>Record review of Resident #2's active orders for February 2024 revealed an order for Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE] mg, Give 2 tablet by mouth every 6 hours as needed for pain, with a start date of [DATE].<br><br>Record review of Resident #2's undated care plan revealed a focus of pain medication therapy, a goal of being free of discomfort or adverse side effects from pain medication and intervention of administer analgesic medication. It further revealed Resident #2 had an actual fall because his knee gave out (no date provided). It further revealed that Resident #2 was at high risk for falls. Further review revealed Resident #2 had acute/chronic pain with a goal of Resident #2 being able to verbalize adequate relief of pain or ability to cope with incompletely relieved pain, and intervention of anticipate need for pain relief and respond immediately to any complaint of pain.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of the facility 802 form (a report of condition of residents including medications) printed on [DATE] revealed Resident #2 was on hypnotic (opiate not marked) and had a fall.<br><br>Record review of Resident #2's February 2024 MAR revealed the following pain medications administered at the following dates and times:<br><br>Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE] MG (Hydrocodone-Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for PAIN:<br><br>-[DATE] at 8:33 pm by LVN A<br><br>-[DATE] at 3:26 pm by RN C<br><br>-[DATE] at 12:53 pm by RN C<br><br>-[DATE] at 8:25 pm by LVN A<br><br>-[DATE] at 8:10 pm by LVN B<br><br>Norco Oral Tablet ,d+[DATE] MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain:<br><br>-[DATE] at 7:47 pm by LVN A<br><br>-[DATE] at 7:22 pm by LVN A<br><br>Tylenol Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain:<br><br>-[DATE] at 7:38 am by RN C<br><br>Review of Resident #2's February 2024 progress note dated [DATE] at 7:38 am revealed a note entered by RN C that stated the resident had a level of pain 6 right now, waiting on triplicate from doctor.<br><br>During an interview on [DATE] at 3:45 pm with Resident #2, he stated that he was in pain because the facility was out of his hydrocodone. He said he was told his prescription expired and there was not a new one; he had been out of his hydrocodone for the last 3 days. He stated his pain went up to a 9 at nighttime, and the facility had run out of his medicine several times in the past, but this was the worst. He stated his pain was on average a 6 without his medicine and a 4 with his medicine. He said without his medicine he could not sleep due to the pain.<br><br>During an interview on [DATE] at 5:50 pm with the DON, she stated that last night ([DATE]) staff had checked that every resident in the facility had all of their pain medications available. She stated she only found out this morning ([DATE]) that Resident #2 was out of hydrocodone, and she stated his medication would be delivered this afternoon.<br><br>Record review of the 24-hour report for [DATE]-[DATE] revealed:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -[DATE] - Resident #2 - Norco re-ordered, complained of pain to right knee; written by LVN F<br><br>-[DATE] - Resident #2 - follow up on Norco, completely out; written by LVN F<br><br>During an interview on [DATE] at 10:15 am with the DON, she stated the harm of residents not receiving or having meds could lead to further illness/complications that may lead a resident to go to the hospital. X-rays needed to be conducted to check for possible fractures and to prevent further pain injuries. Giving meds outside the parameters could cause further illness that may lead to serious medical conditions, and missing medications could lead to further complications/illness/ hospitalization s.<br><br>During an interview on [DATE] at 1:15 pm with the ADM, he stated the harm of not receiving med ications could cause pain or further complications, and illnesses. Not receiving X-rays could lead to pain or further complications of fracture healing. Receiving medications outside parameters could cause more illness or result in infection. Not reporting incidents may cause further sickness, hospitalization , or passing.<br><br>Record review of the undated facility policy titled, Abuse, Neglect and Exploitation, in part, III. Prevention of abuse, neglect, and exploitation, the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect .identify and correct situations of neglect .assuring an assessment of resources needed to provide care and services to all residents .<br><br>Record review of the facility policy and procedure titled, Medication Administration undated revealed in part, 1. All medications are administered by licensed medical or nursing personnel as ordered by the physician and in accordance with professional standards .2.Compare the medication source with the MAR to verify dose and time .3.administer medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.<br><br>Record review of the undated facility policy titled, Pain Management and Treatment, revealed in part, 9. Obtaining pain medications . facility staff will ensure that pain medication is available to residents by the following methods:<br><br>a. Notify primary physician of need for refill and progress noted notification<br><br>b. When pain medicine is provided by Hospice, notify Hospice of need for refill and progress note notification .<br><br>d. if unable to obtain refill from hospice or primary notify the DON .<br><br>e. if a medication is needed it can be pulled from the nexsys system .<br><br>This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 2:36 PM. The ADM and DON were notified. The ADM and DON were provided with the IJ template on [DATE] at 4:15 PM.<br><br>The following plan of Removal (POR) was accepted on [DATE] at 7:21 am and included:<br><br>PLAN OF REMOVAL<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Hico Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 712 Railroad Ave Hico, TX 76457 | |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The notification of Immediate jeopardy states as follows:<br><br>F600 The facility failed to keep the resident free of neglect.<br><br>Resident was admitted with terminal brain cancer and was left in pain after a fall.<br><br>Immediate Interventions:<br><br>1. Consultation and notification made to Medical Director, of Immediate Jeopardy on [DATE] at 4:45 pm by the DON. Ad Hoc QAPI meeting conducted with action plan developed on [DATE] attended by Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Nurse.<br><br>2. On [DATE] the DON and ADON were in-serviced, by Regional Nurse, on neglect, expectations in responding to X-Ray needs, and timeliness of obtaining an X-Ray in the event of an injury and complaints of pain. The DON and ADON then in-serviced the licensed nursing staff to include, newly hired, PRN, and agency, on neglect, expectations in responding to X-Ray needs, timeliness of obtaining an X-Ray in the event of an injury, and complaints of pain on [DATE] and [DATE]. Staff not present will be in-serviced, by DON or designee, prior to next shift. Newly hired will be in-serviced, by DON or designee, upon hire prior to working on the floor. Agency and PRN will not be allowed to work on the floor until in-service and post-test is completed by DON or Designee<br><br>3. On 2/ ,d+[DATE] the DON and ADON were in-serviced , by Regional Nurse, on notification of medication refill needs, when medication card is at the blue on the medication card, or the medication is down to , d+[DATE] days of administration. The DON and ADON then in-serviced the licensed nursing staff to include, newly hired, PRN, and agency, on notification of medication refill needs, when medication card is at the blue on the medication card, or the medication is down to ,d+[DATE] days of administration . Staff not present will be in-serviced, by DON and ADON, prior to next shift. Newly hired will be in-serviced, by DON and ADON, upon hire, prior to working on the floor. Agency and PRN will not be allowed to work on the floor until in-service and post-test is completed by DON and ADON.<br><br>4. On [DATE] the DON, ADON, and 3 licensed nurses completed a pain assessment on all residents to identify any unmet pain needs or change in pain. Completed audit did not identify any unmet pain needs or change in pain. And an audit of medication availability for all residents on pain medications was also completed [DATE] by the ADON, Treatment Nurse, and Regional Nurse. The DON and ADON had oversight of the audit.<br><br>Monitoring:<br><br>1. The DON, ADON, or designee will review 24-hour report daily for any X-Ray orders to ensure timely follow up and intervention occurs. The Care plan will be updated at that time to reflect the intervention. This will be an ongoing monitoring system completed by the DON/ADON.<br><br>2. Administrator or designee, will review this process in the Clinical Meeting scheduled 5 times per week to monitor for compliance, and to make changes based on the interdisciplinary team's decision. This Process Review will be monitored for 12 weeks.<br><br>3. The facility's plan for pain management of new admits will be as follows:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | a) If the resident is coming from home, DON or designee, will ask the resident's family to bring any medications that the resident is currently taking. If not possible, we revert to step c.<br><br>b) If the resident is coming from another nursing facility, DON or designee, will ask the DC facility to send the resident's current med supply. Also, if appropriate, DON or designee, will request the resident be given their medication before they discharge. If not possible, we revert to step c.<br><br>c) If the resident is DC from the hospital, DON or designee, will ask the hospital to medicate prior to discharge. Charge nurse will pull available medications from the nexsys system (supply of extra medication) if necessary. If not available in the nexsys system, DON or designee, will call the PCP and order medications as substitutes until orders arrive. If we still do not have medications, and we cannot treat the resident as ordered, DON or designee, will call 911 and send them back to the hospital.<br><br>d) New admissions medication availability will be monitored, by DON and Administrator, during the morning clinical meeting during weekdays. On weekends, the medication availability will be monitored by the weekend supervisor.<br><br>MONITORING THE POR :<br><br>Record review of in-service sign-in sheets revealed the DON and ADON were in-serviced on [DATE] by the corporate nurse related to Pain medication orders/refills.<br><br>Record review of in-service sign-in sheets revealed the DON and ADON were in-serviced on [DATE] by the corporate nurse related to Post Fall X-Ray Protocol.<br><br>Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to post fall x-ray protocols, which included a post-test.<br><br>Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to pain medication orders/refills, which included a post-test.<br><br>Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to abuse/neglect, which stated at the bottom that it was a refresher for nursing as it was in-serviced in January. No post-test included.<br><br>Record review of in-service sign-in sheets revealed on [DATE] the DON and ADON in-serviced staff related to New Admission Medications and it was documented as completed and signed by RN B and LVN B.<br><br>During an interview on [DATE] at 10:00 am with DON she stated the in-services were conducted 1 on 1 with each nursing staff and a post-test was conducted after. Testing conducted on abuse/neglect was just a refresher as the in-service was conducted back in [DATE] (so no post-test involved), in-service on pain medication orders/refills, post-fall x-ray protocol, and new admission medications along with post-tests was conducted. One LVN who had not been at work would test once she returned before the start of her shift. She and the ADON would make sure the X-ray orders will be reviewed for timeliness ongoing from here on out.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview and observation on [DATE] at 11:00 am Resident #2 stated he was [NAME] today and just got out of bed. He stated that he felt safe, no pain at the moment, and he was safe and doing just fine. No issues or concerns. Observed neat and well-groomed sitting in his wheelchair in the room watching tv.<br><br>During an interview on [DATE] at 12:45 pm with RN B, who worked Sunday 7:00 am - 7:00 pm shift, she stated she was in-serviced on [DATE] one-to-one with DON along with a test after the in-service on ordering narcotics, how to order x-rays for possible fractures, sending residents out for the hospital, making sure medications were available to residents, substitutions for mediation, and abuse/neglect. Report to the abuse coordinator the Administrator immediately if witnessed. Know the signs, gave examples of abuse/neglect, pain medications availability for residents. All the in-services were refresher training for her.<br><br>During an interview on [DATE] at 1:00 pm with LVN B, who worked Sunday 7:00 am - 7:00 pm shift, in-service on [DATE] one-to-one with DON; in-services on medication errors, falling injury, new admits with mediations, In-service on abuse/neglect, know to report if ever witnessed abuse, coordinator is the ADM and the testing was completed after the in-services were conducted.<br><br>During an observation on [DATE] at 1:32 pm LVN D did a pain medication pass for Resident #7 and Resident #6 with no issues with med pass observed.<br><br>During an interview [DATE] at 2:25 pm with LVN C, who worked the 7:00 am - 7:00 pm shift, she stated:<br><br>She was in serviced in the areas of pain management, falls, and abuse and neglect and new admission medications. She said an example of neglect was refusing to give a resident their medications or to feed them. The ADM was the abuse and neglect coordinator. She revealed the post fall x-ray in service instructed staff to enter information in EHR, call the company they contract with to do x-rays and if they are unavailable, to call 911 and have the resident transported to the hospital. Notify the RP, PCP, and if on Hospice, Hospice. If resident was on hospice, still notify the PCP. Make sure that the residents' pain medications are available and check availability. If pain medication is in pill form, and on a medication card, when the medication gets to the blue line, call to re-order to call hospice for renewal. If resident is on Hospice, make sure Hospice is informed about any need to obtain medication. If pain medication is needed, with a 2nd nurse, obtain from the electronic e-kit. If there are any problems, phone the DON. If there is a new resident admission get the medications from the family and check them against the PCP orders and place any needed pharmacy orders. If the resident comes from the hospital, ask the hospital to medicate prior to sending the resident to them. The charge nurse will put the medications in the electronic e-kit if needed. If they are not available in the electronic e-kit, the DON or will call the PCP and get medication substitutions.<br><br>During an interview on [DATE] at 2:20 pm with LVN D, who works 5 days a week 7:00 am - 3:00 pm shift, she stated:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | She was in serviced on abuse and neglect - she said abuse is yelling at somebody and named the ADM as the abuse/neglect coordinator. She was in serviced on post fall x-ray protocol. The in service instructed to put the order PCC, call the x-ray contracting service and give them the order. If the contract service is unavailable, call the clinic or ER. When this is done notify DON, MD, ADM, and family. She was in serviced on new admission medications and told to get medications from the family until they get the pharmacy refills, if the resident is discharged from the hospital, ask the hospital to give all medications prior to coming to the facility, medications will be put into the electronic e-kit and if the resident needs a medication that is not in the e-kit, call the DON, family, and they will call the PCP and get substitutes until the facility gets the orders. When a resident has a pain medication, always be on the lookout to make sure they have enough medications. Let Hospice know of all refills needs. Communicate with Hospice. If you have to get a pain medication from the electronic e-kit, take a second nurse and obtain the medication. If you can't get a medication you need, call the DON.<br><br>During an interview on [DATE] at 2:58 pm with LVN E, who works 3:00 pm - 11:00 pm shift, she stated:<br><br>She was in serviced on pain management, x-rays, abuse and neglect, and new admission medication. She gave the examples of yelling at a resident as abuse and referring to a resident as a, feeder. She identified the ADM as the abuse and neglect coordinator. She said, with pain pills, when they are empty at the blue they need to be reordered. The important issue is to not let medications run out. Call Hospice if there are problems with the Hospice resident medications. With new residents, get medications from the family and if resident coming from the hospital, call the hospital and ask them to medicate resident prior to leaving the hospital. If a pain medication is not available, with a second nurse, get medications from the electronic e-kit system. If there is a problem getting a medication, call the DON. If a new resident does not have medications at the facility, call the DON and she will call their PCP to get a substitute medication until the residents prescription comes in. When an x-ray is needed, enter to necessary information into PCC and call the contract x-ray service. If they can't come, call EMS and send resident out. Always inform the RP, DON, and MD when a resident goes to the hospital. Always communicate with the DON and Hospice (if a Hospice resident) about medication needs and or issues.<br><br>During an interview on [DATE] at 1:15 pm with the ADM, he stated in-services with nursing staff were started on [DATE] with one LVN that had not been at work needing to be in-service. That in-service will take place before her next shift. In-service along with testing was conducted one to one; the Adm verified and read off on all the in-services of nursing staff, abuse/neglect in-service was conducted in regard to making sure x-rays conducted, medication availability, when to call medications in, and the effects of what the facility will do if medication not available. Proper handling of new admissions and if medications come from home or another facility or hospital. Pain management assessment on all residents was completed on [DATE] along with an audit of medication availability of all residents. The DON/ADON will review x-ray 24-report daily and the administrator will review daily for the next 12 weeks for each medication given. And make sure the new patient admission protocol is followed.<br><br>The ADM was informed the Immediate Jeopardy was removed on [DATE] at 3:15 p.m. The facility remained out of compliance at a scope of pattern with potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46565<br><br>Based on observation, interview and record review, the facility failed to ensure it developed and implemented written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for two (Resident #1, Resident #2) of five residents reviewed for neglect.<br><br>The facility failed to implement its policies and procedures that were designed to prevent abuse, neglect and exploitation by failing to:<br><br>1. ensure Resident #1's pain in her arm and hip was addressed after a fall on [DATE] by providing her prescribed tramadol which had run out and hospice nurse reported constant pain in left forearm<br><br>2. ensure Resident #1's neuro checks were completed and documented after a fall [DATE] in which she hit her head and displayed an increase in confusion<br><br>3. ensure Resident #1's x-rays were performed in a timely manner after a fall on [DATE] after which she complained of pain and x-rays were not performed until [DATE]<br><br>4. ensure Resident #2's pain was addressed by providing his prescribed hydrocodone for 3 days while it had run out leading to pain that went as high as a 9, especially at night causing inability to sleep, but averaged at a 6 for the duration of this time when his medication was unavailable<br><br>An immediate jeopardy situation was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:15 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with a severity of potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>These failures led to uncontrolled pain and unidentified injuries and placed all residents at risk of not having their needs met to reach their highest practicable mental, physical and psycho-social wellbeing.<br><br>Findings included:<br><br>Resident #1<br><br>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including syncope (fainting due to a decrease in blood flow to the brain), glaucoma (a condition where the eye's optic nerve is damaged), and abnormal brain scan.<br><br>Review of Resident #1's [DATE] orders revealed the following:<br><br>*Portable X-ray to left upper extremity. Maybe fractured after a fall. C/o lots of pain, dated [DATE].<br><br>*X-ray of left lower extremity(hip/pelvis) left upper extremity shoulder, left ribs dated [DATE].<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | *Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 4 hours as needed for pain dated [DATE].<br><br>*Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every morning and at bedtime for Pain related to NEOPLASM (cancer) OF UNSPECIFIED BEHAVIOR OF BRAIN dated [DATE].<br><br>Review of Resident #1's Resident Information sheet in her admission packet, dated [DATE], reflected the FM as her emergency contact and responsibly party.<br><br>Review of Resident #1's admission MDS assessment, dated [DATE], reflected a BIMS (assessment of cognitive function) was not conducted. It further revealed Resident #1 received no intervention for pain. Review further revealed no falls since admission or prior to admission. Further review revealed Resident #1 required setup or cleanup assistance with toileting hygiene.<br><br>Review of Resident #1's undated care plan, reflected it had a focus of admission to hospice with a goal of keeping Resident #1 as comfortable as possible and intervention of administer pain medications as ordered and assess for verbal and non-verbal signs/symptoms of pain or discomfort all initiated on [DATE]. Further review revealed the care plan had a focus dated [DATE], and reflected she had an actual fall with no serious injury due to unsteady gait with an intervention of having a PT consult for strength and mobility. An intervention of For no apparent acute injury, determine and address causative factors of the fall and it was initiated [DATE].<br><br>Review of the facility self-report revealed Resident #1 suffered a fall on [DATE] at 5:47 am.<br><br>Review of Resident #1's [DATE] progress notes revealed no progress note related to the fall on [DATE].<br><br>Review of Resident #1's hospice progress by HRN A note dated [DATE] (no time on note) revealed Resident #1 had a fall per RN A and was sitting in her wheelchair when hospice arrived. The note reflected Resident #1 complained of pain to the left upper arm, and a hematoma (swollen knot) was noted to the left side of her head and she had a sore upper arm with continuous pain to arm. Resident #1 needed refills of tramadol and lorazepam and it was called in to the facility pharmacy. The note reflected the hospice doctor requested an order for a portable x-ray to the left upper arm.<br><br>Review of Resident #1's entire EHR from her admission in [DATE] through her discharge in [DATE] revealed no neuro checks documented in any portion (including assessments, progress notes, and miscellaneous).<br><br>Review of Resident #1's progress notes, from [DATE] through [DATE], revealed the following:<br><br>*[DATE] 11:38 am: tramadol HCl Oral Tablet 50 MG, Med not available Hospice nurse will have med delivered by RN A.<br><br>*[DATE] 9:20 pm: tramadol HCl Oral Tablet 50 MG, Medication unavailable; Hospice notified [DATE] at 6:00 am by LVN A.<br><br>*[DATE] 6:03 am: tramadol HCl Oral Tablet 50 MG, Medication unavailable by LVN A.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of Resident #1's [DATE] MAR revealed her tramadol was administered [DATE] at 8:17 pm; missing her scheduled bedtime dose [DATE], morning dose [DATE] and PRN doses after her fall.<br><br>Review of Resident #1's x-ray of the left hip dated [DATE] revealed a possible fracture through the neck of the left femur (long bone in the leg) and recommended CT scan to correlate findings.<br><br>During an observation on [DATE] at 5:10 pm with Resident #1 at a new facility, revealed she looked like she was trying to stay very still. She was not able to answer questions, and was tucked under blankets with pillows and padding around her.<br><br>During an interview on [DATE] at 5:15 pm with the New Facility ADM, she stated Resident #1 was comfortable when she did not move, but when staff had to reposition her or change her she was in excruciating pain and would yell out with tears in her eyes. New Facility was pre-medicating Resident #1 with pain medicine before having to reposition her but she was still in pain. The New Facility ADM stated that Resident #1 admitted with severe pain in her left hip and blanching and redness to her skin from a pressure injury to her coccyx.<br><br>During an interview on [DATE] at 12:36 pm LVN A stated that she answered a call light for the room next to Resident #1 and that resident heard a fall in the con-joined bathroom. LVN A found Resident #1 had fallen, urine was on the floor and her walker was folded against the door. She stated Resident #1 had a hematoma (swollen knot) to her right forehead and pain in her left arm. She stated the internet was down, so she could not see Resident #1's face sheet to notify the FM. She texted the DON that Resident #1 had an unwitnessed fall and a red raised area to the right front side of the head and complained of pain in her left shoulder with vitals bp ,d+[DATE], pulse 102, resp 18, O2 at 87 on room air (applied oxygen) and a temperature of 97.7. degrees Fahrenheit. The DON got the hospice provider's phone number and hospice was notified. Hospice stated they would notify the FM. LVN A initiated neuro checks on paper due to lack of access to the EHR. LVN A stated she administered the last tramadol to Resident #1 shortly after her fall and informed hospice that Resident #1 needed tramadol and lorazepam. LVN A left the paper to continue the neuro checks with RN A when LVN A's shift ended. RN A took over care of Resident #1 on [DATE] (day of fall) at 7:00 am.<br><br>During an interview on [DATE] at 11:30 am with RN A she stated that she administered tramadol to Resident #1 on the day of her fall ([DATE]) when prompted she said she would have put it in the MAR. She stated she entered x-ray that hospice doctor ordered on [DATE] and then called the x-ray company. RN A then stated that she was not working the day that the x-ray was ordered and that the DON called the x-ray company . RN A stated she did not remember if she performed neuro checks or not on Resident #1. RN A cared for Resident #1 on [DATE] - [DATE] (discharge). RN A was not able to answer all questions asked and when she answered she gave conflicting information multiple times.<br><br>Record review of Resident #1's [DATE] vitals revealed no blood pressure, respiratory rate, temperature, nor pulse entered by RN A on [DATE], [DATE], nor [DATE] (dates neuro checks should have been done).<br><br>Record review of Resident #1's discharge summary dated [DATE] at 2:28 pm created by RN A revealed Resident #1 was discharged to another facility on [DATE] at 2:54 pm.<br><br>Record review of Resident #1's [DATE] vitals revealed the following pain assessments:<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -[DATE] 12:00 am level 4 entered by DON<br><br>-[DATE] 5:46 am level 4 entered by LVN A<br><br>-[DATE] 7:00 am level 3 entered by LVN A<br><br>-[DATE] 7:32 am level 3 entered by LVN A<br><br>-[DATE] 8:31 am level 3 entered by LVN A<br><br>-[DATE] 11:38 am level 4 entered by RN A<br><br>-[DATE] 9:30 pm level 3 entered by LVN A<br><br>-[DATE] 1:36 am level 3 entered by LVN A<br><br>-[DATE] 8:17 pm level 7 entered by LVN F<br><br>-[DATE] 5:30 am level 3 entered by LVN A<br><br>-[DATE] 8:13 am level 0 entered by Former Employee<br><br>-[DATE] 9:25 pm level 8 entered by LVN F<br><br>-[DATE] 8:56 am level 6 entered by RN A<br><br>-[DATE] 9:00 am level 4 entered by the DON<br><br>Record review of Resident #1's 24- hour report for [DATE]-[DATE] revealed:<br><br>-[DATE] - no entry for Resident #1.<br><br>-[DATE] - Resident #1 showing increased confusion, no record of a fall entered by LVN A<br><br>-[DATE] - X-ray will be done tomorrow ([DATE]) for x-ray to left hip; fall on [DATE], x-ray ordered, and no tramadol entered by LVN F.<br><br>-[DATE] - blank, all entries reflected to see [DATE] entered by LVN F.<br><br>-[DATE] - Resident #1 7a-3p shift - neuro's, left at 3:00 pm, person who documented this did not fill out his/her name.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675468 | A. Building<br>B. Wing | 03/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hico Nursing and Rehabilitation | 712 Railroad Ave<br>Hico, TX 76457 |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on [DATE] at 5:50 pm the DON she stated she was not at work [DATE], the day Resident #1 fell . She then stated the results from Resident #1's post-fall x-rays (of her left hip, ribs, and shoulder but not forearm) were reported to the facility on [DATE] (same day as the x-rays were done). The DON stated the internet was down [DATE] due to high winds and the facility was notified that the x-ray company would not be able to do the x-ray until [DATE] due to the weather. The DON stated that because the internet was down, Resident #1's neuro checks were written on paper. She was unable to produce the paper and stated it was lost and she could not find the paper with the neuro checks on it. She stated the neuro checks were never entered into the EHR. She said she would usually collect information documented on paper and ensure it was entered into the EHR. She stated that tramadol was not in the hospice comfort kit and medication for hospice residents could not be pulled from the nexsys supply.<br><br>During an interview on [DATE] at 10:47 am with the FM she stated she was not notified that the x-rays were not going to be done until [DATE] nor was she told she could send Resident #1 to the hospital for immediate evaluation. If she had been told there was going to be a 2-day delay for x-rays she would have sent Resident #1 to the hospital. The FM stated Resident #1 was guarding her left arm and stated she was in pain at 2:00 pm on [DATE] when she visited.<br><br>During an interview on [DATE] at 11:35 am the Hospice Nurse stated that when she saw Resident #1 after the fall, she had a complete decline in function that was directly attributed to the fall. She stated she re-ordered pain medication for Resident #1 before the weekend of [DATE]-14th, so Resident #1 would not run out. She did not know why the medication did not arrive before [DATE]. She stated Resident #1 was in constant pain from the time of the fall and including the time she was admitted to the new facility. She said the new facility pre-medicated Resident #1 prior to moving her, but Resident #1 was still in pain unless she lies still.<br><br>Resident #2<br><br>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including acute post-procedural pain, spinal stenosis (narrowing of the spine), gout, and repeated falls.<br><br>Record review of Resident #2's annual MDS dated [DATE] revealed Resident #2 had a BIMS of 15, which indicated he was cognitively intact. It further revealed that Resident #2 had experience pain or hurting frequently in the past 5 days and that he had not experienced any falls since admission.<br><br>Record review of Resident #2's active orders for February 2024 revealed an order for Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE] mg, Give 2 tablet by mouth every 6 hours as needed for pain, with a start date of [DATE].<br><br>Record review of Resident #2's undated care plan revealed a focus of pain medication therapy, a goal of being free of discomfort or adverse side effects from pain medication and intervention of administer analgesic medication. It further revealed Resident #2 had an actual fall because his knee gave out (no date provided). It further revealed that Resident #2 was at high risk for falls. Further review revealed Resident #2 had acute/chronic pain with a goal of Resident #2 being able to verbalize adequate relief of pain or ability to cope with incompletely relieved pain, and intervention of anticipate need for pain relief and respond immediately to any complaint of pain.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Hico Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 712 Railroad Ave Hico, TX 76457 | |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of the facility 802 form (a report of condition of residents including medications) printed on [DATE] revealed Resident #2 was on hypnotic (opiate not marked) and had a fall.<br><br>Record review of Resident #2's February 2024 MAR revealed the following pain medications administered at the following dates and times:<br><br>Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE] MG (Hydrocodone-Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for PAIN:<br><br>-[DATE] at 8:33 pm by LVN A<br><br>-[DATE] at 3:26 pm by RN C<br><br>-[DATE] at 12:53 pm by RN C<br><br>-[DATE] at 8:25 pm by LVN A<br><br>-[DATE] at 8:10 pm by LVN B<br><br>Norco Oral Tablet ,d+[DATE] MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain:<br><br>-[DATE] at 7:47 pm by LVN A<br><br>-[DATE] at 7:22 pm by LVN A<br><br>Tylenol Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain:<br><br>-[DATE] at 7:38 am by RN C<br><br>Review of Resident #2's February 2024 progress note dated [DATE] at 7:38 am revealed a note entered by RN C that stated the resident had a level of pain 6 right now, waiting on triplicate from doctor.<br><br>During an interview on [DATE] at 3:45 pm with Resident #2, he stated that he was in pain because the facility was out of his hydrocodone. He said he was told his prescription expired and there was not a new one; he had been out of his hydrocodone for the last 3 days. He stated his pain went up to a 9 at nighttime, and the facility had run out of his medicine several times in the past, but this was the worst. He stated his pain was on average a 6 without his medicine and a 4 with his medicine. He said without his medicine he could not sleep due to the pain.<br><br>During an interview on [DATE] at 5:50 pm with the DON, she stated that last night ([DATE]) staff had checked that every resident in the facility had all of their pain medications available. She stated she only found out this morning ([DATE]) that Resident #2 was out of hydrocodone, and she stated his medication would be delivered this afternoon.<br><br>Record review of the 24-hour report for [DATE]-[DATE] revealed:<br><br>(continued on next page) |

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F 0607

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

-[DATE] - Resident #2 - Norco re-ordered, complained of pain to right knee; written by LVN F

-[DATE] - Resident #2 - follow up on Norco, completely out; written by LVN F

During an interview on [DATE] at 10:15 am with the DON, she stated the harm of residents not receiving or having meds could lead to further illness/complications that may lead a resident to go to the hospital. X-rays needed to be conducted to check for possible fractures and to prevent further pain injuries. Giving meds outside the parameters could cause further illness that may lead to serious medical conditions, and missing medications could lead to further complications/illness/ hospitalization s.

During an interview on [DATE] at 1:15 pm with the ADM, he stated the harm of not receiving med ications could cause pain or further complications, and illnesses. Not receiving X-rays could lead to pain or further complications of fracture healing. Receiving medications outside parameters could cause more illness or result in infection. Not reporting incidents may cause further sickness, hospitalization , or passing.

Record review of the undated facility policy titled, Abuse, Neglect and Exploitation, in part, III. Prevention of abuse, neglect, and exploitation, the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect .identify and correct situations of neglect .assuring an assessment of resources needed to provide care and services to all residents .

Record review of the facility policy and procedure titled, Medication Administration undated revealed in part, 1. All medications are administered by licensed medical or nursing personnel as ordered by the physician and in accordance with professional standards .2.Compare the medication source with the MAR to verify dose and time .3.administer medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.

Record review of the undated facility policy titled, Pain Management and Treatment, revealed in part, 9. Obtaining pain medications . facility staff will ensure that pain medication is available to residents by the following methods:

a. Notify primary physician of need for refill and progress noted notification

b. When pain medicine is provided by Hospice, notify Hospice of need for refill and progress note notification .

d. if unable to obtain refill from hospice or primary notify the DON .

e. if a medication is needed it can be pulled from the nexsys system .

This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 2:36 PM. The ADM and DON were notified. The ADM and DON were provided with the IJ template on [DATE] at 4:15 PM.

The following plan of Removal (POR) was accepted on [DATE] at 7:21 am and included:

PLAN OF REMOVAL

(continued on next page)

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The notification of Immediate jeopardy states as follows:<br><br>F600 The facility failed to keep the resident free of neglect.<br><br>Resident was admitted with terminal brain cancer and was left in pain after a fall.<br><br>Immediate Interventions:<br><br>1. Consultation and notification made to Medical Director, of Immediate Jeopardy on [DATE] at 4:45 pm by the DON. Ad Hoc QAPI meeting conducted with action plan developed on [DATE] attended by Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Nurse.<br><br>2. On [DATE] the DON and ADON were in-serviced, by Regional Nurse, on neglect, expectations in responding to X-Ray needs, and timeliness of obtaining an X-Ray in the event of an injury and complaints of pain. The DON and ADON then in-serviced the licensed nursing staff to include, newly hired, PRN, and agency, on neglect, expectations in responding to X-Ray needs, timeliness of obtaining an X-Ray in the event of an injury, and complaints of pain on [DATE] and [DATE]. Staff not present will be in-serviced, by DON or designee, prior to next shift. Newly hired will be in-serviced, by DON or designee, upon hire prior to working on the floor. Agency and PRN will not be allowed to work on the floor until in-service and post-test is completed by DON or Designee<br><br>3. On 2/ ,d+[DATE] the DON and ADON were in-serviced , by Regional Nurse, on notification of medication refill needs, when medication card is at the blue on the medication card, or the medication is down to , d+[DATE] days of administration. The DON and ADON then in-serviced the licensed nursing staff to include, newly hired, PRN, and agency, on notification of medication refill needs, when medication card is at the blue on the medication card, or the medication is down to ,d+[DATE] days of administration . Staff not present will be in-serviced, by DON and ADON, prior to next shift. Newly hired will be in-serviced, by DON and ADON, upon hire, prior to working on the floor. Agency and PRN will not be allowed to work on the floor until in-service and post-test is completed by DON and ADON.<br><br>4. On [DATE] the DON, ADON, and 3 licensed nurses completed a pain assessment on all residents to identify any unmet pain needs or change in pain. Completed audit did not identify any unmet pain needs or change in pain. And an audit of medication availability for all residents on pain medications was also completed [DATE] by the ADON, Treatment Nurse, and Regional Nurse. The DON and ADON had oversight of the audit.<br><br>Monitoring:<br><br>1. The DON, ADON, or designee will review 24-hour report daily for any X-Ray orders to ensure timely follow up and intervention occurs. The Care plan will be updated at that time to reflect the intervention. This will be an ongoing monitoring system completed by the DON/ADON.<br><br>2. Administrator or designee, will review this process in the Clinical Meeting scheduled 5 times per week to monitor for compliance, and to make changes based on the interdisciplinary team's decision. This Process Review will be monitored for 12 weeks.<br><br>3. The facility's plan for pain management of new admits will be as follows:<br><br>(continued on next page) |

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F 0607

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

a) If the resident is coming from home, DON or designee, will ask the resident's family to bring any medications that the resident is currently taking. If not possible, we revert to step c.

b) If the resident is coming from another nursing facility, DON or designee, will ask the DC facility to send the resident's current med supply. Also, if appropriate, DON or designee, will request the resident be given their medication before they discharge. If not possible, we revert to step c.

c) If the resident is DC from the hospital, DON or designee, will ask the hospital to medicate prior to discharge. Charge nurse will pull available medications from the nexsys system (supply of extra medication) if necessary. If not available in the nexsys system, DON or designee, will call the PCP and order medications as substitutes until orders arrive. If we still do not have medications, and we cannot treat the resident as ordered, DON or designee, will call 911 and send them back to the hospital.

d) New admissions medication availability will be monitored, by DON and Administrator, during the morning clinical meeting during weekdays. On weekends, the medication availability will be monitored by the weekend supervisor.

MONITORING THE POR :

Record review of in-service sign-in sheets revealed the DON and ADON were in-serviced on [DATE] by the corporate nurse related to Pain medication orders/refills.

Record review of in-service sign-in sheets revealed the DON and ADON were in-serviced on [DATE] by the corporate nurse related to Post Fall X-Ray Protocol.

Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to post fall x-ray protocols, which included a post-test.

Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to pain medication orders/refills, which included a post-test.

Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to abuse/neglect, which stated at the bottom that it was a refresher for nursing as it was in-serviced in January. No post-test included.

Record review of in-service sign-in sheets revealed on [DATE] the DON and ADON in-serviced staff related to New Admission Medications and it was documented as completed and signed by RN B and LVN B.

During an interview on [DATE] at 10:00 am with DON she stated the in-services were conducted 1 on 1 with each nursing staff and a post-test was conducted after. Testing conducted on abuse/neglect was just a refresher as the in-service was conducted back in [DATE] (so no post-test involved), in-service on pain medication orders/refills, post-fall x-ray protocol, and new admission medications along with post-tests was conducted. One LVN who had not been at work would test once she returned before the start of her shift. She and the ADON would make sure the X-ray orders will be reviewed for timeliness ongoing from here on out.

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview and observation on [DATE] at 11:00 am Resident #2 stated he was [NAME] today and just got out of bed. He stated that he felt safe, no pain at the moment, and he was safe and doing just fine. No issues or concerns. Observed neat and well-groomed sitting in his wheelchair in the room watching tv.<br><br>During an interview on [DATE] at 12:45 pm with RN B, who worked Sunday 7:00 am - 7:00 pm shift, she stated she was in-serviced on [DATE] one-to-one with DON along with a test after the in-service on ordering narcotics, how to order x-rays for possible fractures, sending residents out for the hospital, making sure medications were available to residents, substitutions for mediation, and abuse/neglect. Report to the abuse coordinator the Administrator immediately if witnessed. Know the signs, gave examples of abuse/neglect, pain medications availability for residents. All the in-services were refresher training for her.<br><br>During an interview on [DATE] at 1:00 pm with LVN B, who worked Sunday 7:00 am - 7:00 pm shift, in-service on [DATE] one-to-one with DON; in-services on medication errors, falling injury, new admits with mediations, In-service on abuse/neglect, know to report if ever witnessed abuse, coordinator is the ADM and the testing was completed after the in-services were conducted.<br><br>During an observation on [DATE] at 1:32 pm LVN D did a pain medication pass for Resident #7 and Resident #6 with no issues with med pass observed.<br><br>During an interview [DATE] at 2:25 pm with LVN C, who worked the 7:00 am - 7:00 pm shift, she stated:<br><br>She was in serviced in the areas of pain management, falls, and abuse and neglect and new admission medications. She said an example of neglect was refusing to give a resident their medications or to feed them. The ADM was the abuse and neglect coordinator. She revealed the post fall x-ray in service instructed staff to enter information in EHR, call the company they contract with to do x-rays and if they are unavailable, to call 911 and have the resident transported to the hospital. Notify the RP, PCP, and if on Hospice, Hospice. If resident was on hospice, still notify the PCP. Make sure that the residents' pain medications are available and check availability. If pain medication is in pill form, and on a medication card, when the medication gets to the blue line, call to re-order to call hospice for renewal. If resident is on Hospice, make sure Hospice is informed about any need to obtain medication. If pain medication is needed, with a 2nd nurse, obtain from the electronic e-kit. If there are any problems, phone the DON. If there is a new resident admission get the medications from the family and check them against the PCP orders and place any needed pharmacy orders. If the resident comes from the hospital, ask the hospital to medicate prior to sending the resident to them. The charge nurse will put the medications in the electronic e-kit if needed. If they are not available in the electronic e-kit, the DON or will call the PCP and get medication substitutions.<br><br>During an interview on [DATE] at 2:20 pm with LVN D, who works 5 days a week 7:00 am - 3:00 pm shift, she stated:<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | She was in serviced on abuse and neglect - she said abuse is yelling at somebody and named the ADM as the abuse/neglect coordinator. She was in serviced on post fall x-ray protocol. The in service instructed to put the order PCC, call the x-ray contracting service and give them the order. If the contract service is unavailable, call the clinic or ER. When this is done notify DON, MD, ADM, and family. She was in serviced on new admission medications and told to get medications from the family until they get the pharmacy refills, if the resident is discharged from the hospital, ask the hospital to give all medications prior to coming to the facility, medications will be put into the electronic e-kit and if the resident needs a medication that is not in the e-kit, call the DON, family, and they will call the PCP and get substitutes until the facility gets the orders. When a resident has a pain medication, always be on the lookout to make sure they have enough medications. Let Hospice know of all refills needs. Communicate with Hospice. If you have to get a pain medication from the electronic e-kit, take a second nurse and obtain the medication. If you can't get a medication you need, call the DON.<br><br>During an interview on [DATE] at 2:58 pm with LVN E, who works 3:00 pm - 11:00 pm shift, she stated:<br><br>She was in serviced on pain management, x-rays, abuse and neglect, and new admission medication. She gave the examples of yelling at a resident as abuse and referring to a resident as a, feeder. She identified the ADM as the abuse and neglect coordinator. She said, with pain pills, when they are empty at the blue they need to be reordered. The important issue is to not let medications run out. Call Hospice if there are problems with the Hospice resident medications. With new residents, get medications from the family and if resident coming from the hospital, call the hospital and ask them to medicate resident prior to leaving the hospital. If a pain medication is not available, with a second nurse, get medications from the electronic e-kit system. If there is a problem getting a medication, call the DON. If a new resident does not have medications at the facility, call the DON and she will call their PCP to get a substitute medication until the residents prescription comes in. When an x-ray is needed, enter to necessary information into PCC and call the contract x-ray service. If they can't come, call EMS and send resident out. Always inform the RP, DON, and MD when a resident goes to the hospital. Always communicate with the DON and Hospice (if a Hospice resident) about medication needs and or issues.<br><br>During an interview on [DATE] at 1:15 pm with the ADM, he stated in-services with nursing staff were started on [DATE] with one LVN that had not been at work needing to be in-service. That in-service will take place before her next shift. In-service along with testing was conducted one to one; the Adm verified and read off on all the in-services of nursing staff, abuse/neglect in-service was conducted in regard to making sure x-rays conducted, medication availability, when to call medications in, and the effects of what the facility will do if medication not available. Proper handling of new admissions and if medications come from home or another facility or hospital. Pain management assessment on all residents was completed on [DATE] along with an audit of medication availability of all residents. The DON/ADON will review x-ray 24-report daily and the administrator will review daily for the next 12 weeks for each medication given. And make sure the new patient admission protocol is followed.<br><br>The ADM was informed the Immediate Jeopardy was removed on [DATE] at 3:15 p.m. The facility remained out of compliance at a scope of pattern with potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949<br><br>Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect resulted in bodily injury, to other officials (including the State Agency) for one (Resident #1) of five residents reviewed for abuse, neglect, and misappropriation of property, in that:<br><br>The facility failed to:<br><br>-Report to the State Agency (SA) within two hours after Resident #1 had a fall on 01/14/24 at 5:57 am and the subsequent x-ray results reflected a possible fracture to her left femur.<br><br>This failure could place residents at risk of not having injuries related to abuse, neglect, reported.<br><br>Findings included:<br><br>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including syncope (fainting due to a decrease in blood flow to the brain), glaucoma (a condition where the eye's optic nerve is damaged), and abnormal brain scan.<br><br>Review of Resident #1's January 2024 orders revealed the following:<br><br>*Portable X-ray to left upper extremity. Maybe fractured after a fall. C/o lots of pain, dated 01/14/24.<br><br>*X-ray of left lower extremity(hip/pelvis) left upper extremity shoulder, left ribs dated 01/16/24.<br><br>*Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 4 hours as needed for pain dated 01/03/24.<br><br>*Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every morning and at bedtime for Pain related to NEOPLASM (cancer) OF UNSPECIFIED BEHAVIOR OF BRAIN dated 01/10/24.<br><br>Review of Resident #1's admission MDS assessment, dated 12/20/23, reflected a BIMS (assessment of cognitive function) was not conducted. It further revealed Resident #1 received no intervention for pain. Review further revealed no falls since admission or prior to admission. Further review revealed Resident #1 required setup or cleanup assistance with toileting hygiene.<br><br>Review of the 1/17/2024 at 8:06 pm facility self-report to the SA revealed Resident #1 suffered a fall on 01/14/24 at 5:47 am; initial assessment showed a bump on Resident #1's head and complaints of left shoulder pain. The following day (01/15/24) pain was increased and imaging was ordered which revealed possible fracture to her left femur. ADM reported Resident #1's fracture at this time.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675468 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/07/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Hico Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 712 Railroad Ave Hico, TX 76457 | |

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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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's January 2024 progress notes revealed no progress note related to the fall.<br><br>Review of Resident #1's incident report, dated 01/14/24, reflected the following:<br><br>Nursing description of the event: [Resident #1] was self-transferring to the bathroom and urinated, slipping in the urine causing a fall .<br><br>Review of Resident #1's admission care plan, dated 01/15/24, reflected she had an actual fall with no serious injury due to unsteady gait with an intervention of having a PT consult for strength and mobility.<br><br>Review of Resident #1's x-ray results, dated 01/16/24 at 3:34 PM, reflected a possible fracture through the neck of left femur.<br><br>During an interview on 02/23/24 at 5:50 pm with the DON, she stated the results from Resident #1's post-fall x-rays were reported to the facility on [DATE]. She stated that she was both the Administrator and DON for so long, from July 2023 until [DATE], that she had to re-learn to report things to the Administrator who had just started with the facility on 01/11/24. She could not remember when she provided the information to the Administrator for him to report it.<br><br>Record review of the Incident and Accidents policy, last revised 01/01/23, revealed .purpose .meet regulatory requirements for reporting of incidents and accidents . |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46565<br><br>Based on observation, interview and record review, the facility failed to 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 residents' goals and preferences for two (Resident #1, Resident #2) of five residents reviewed for pain.<br><br>The facility failed to:<br><br>1. ensure Resident #1's prescribed tramadol was in the facility and provided to Resident #1 for her pain after<br><br>Resident #1 suffered a fall on [DATE] around 5:47 am and reported constant pain in her left arm and had a visible hematoma (swollen knot) on her right forehead.<br><br>2. ensure Resident #2's prescribed hydrocodone was in the facility and available to Resident #2 for 3 days which led to pain that went as high as a 9, especially at night, which caused sleep loss, and pain that averaged a 6 for the duration of the time his medication was unavailable<br><br>An immediate jeopardy situation was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:15 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with a severity of potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>These failures could affect residents by placing them at risk for pain that would prevent residents from achieving their highest practicable physical, mental and psychosocial well-being.<br><br>Findings included:<br><br>Resident #1<br><br>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including syncope (fainting due to a decrease in blood flow to the brain), glaucoma (a condition where the eye's optic nerve is damaged), and abnormal brain scan.<br><br>Review of Resident #1's [DATE] orders revealed the following:<br><br>*Portable X-ray to left upper extremity. Maybe fractured after a fall. C/o lots of pain, dated [DATE].<br><br>*X-ray of left lower extremity(hip/pelvis) left upper extremity shoulder, left ribs dated [DATE].<br><br>*Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 4 hours as needed for pain dated [DATE].<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | *Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every morning and at bedtime for Pain related to NEOPLASM (cancer) OF UNSPECIFIED BEHAVIOR OF BRAIN dated [DATE].<br><br>Review of Resident #1's Resident Information sheet in her admission packet, dated [DATE], reflected the FM as her emergency contact and responsibly party.<br><br>Review of Resident #1's admission MDS assessment, dated [DATE], reflected a BIMS (assessment of cognitive function) was not conducted. It further revealed Resident #1 received no intervention for pain. Review further revealed no falls since admission or prior to admission. Further review revealed Resident #1 required setup or cleanup assistance with toileting hygiene.<br><br>Review of Resident #1's undated care plan, reflected it had a focus of admission to hospice with a goal of keeping Resident #1 as comfortable as possible and intervention of administer pain medications as ordered and assess for verbal and non-verbal signs/symptoms of pain or discomfort all initiated on [DATE]. Further review revealed the care plan had a focus dated [DATE], and reflected she had an actual fall with no serious injury due to unsteady gait with an intervention of having a PT consult for strength and mobility. An intervention of For no apparent acute injury, determine and address causative factors of the fall and it was initiated [DATE].<br><br>Review of the facility self-report revealed Resident #1 suffered a fall on [DATE] at 5:47 am.<br><br>Review of Resident #1's [DATE] progress notes revealed no progress note related to the fall on [DATE].<br><br>Review of Resident #1's hospice progress by HRN A note dated [DATE] (no time on note) revealed Resident #1 had a fall per RN A and was sitting in her wheelchair when hospice arrived. The note reflected Resident #1 complained of pain to the left upper arm, and a hematoma (swollen knot) was noted to the left side of her head and she had a sore upper arm with continuous pain to arm. Resident #1 needed refills of tramadol and lorazepam and it was called in to the facility pharmacy. The note reflected the hospice doctor requested an order for a portable x-ray to the left upper arm.<br><br>Review of Resident #1's progress notes, from [DATE] through [DATE], revealed the following:<br><br>*[DATE] 11:38 am: tramadol HCl Oral Tablet 50 MG, Med not available Hospice nurse will have medication delivered authored by RN A.<br><br>*[DATE] 9:20 pm: tramadol HCl Oral Tablet 50 MG, Medication unavailable; Hospice notified [DATE] at 6:00 am authored by LVN A.<br><br>*[DATE] 6:03 am: tramadol HCl Oral Tablet 50 MG, Medication unavailable authored by LVN A.<br><br>Review of Resident #1's [DATE] MAR revealed her tramadol was administered [DATE] at 8:17 pm; missing her scheduled bedtime dose [DATE], morning dose [DATE] and PRN doses after her fall.<br><br>Review of Resident #1's x-ray of the left hip dated [DATE] revealed a possible fracture through the neck of the left femur (long bone in the leg) and recommended CT scan to correlate findings.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an observation on [DATE] at 5:10 pm with Resident #1 at a new facility, revealed she looked like she was trying to stay very still. She was not able to answer questions, and was tucked under blankets with pillows and padding around her.<br><br>During an interview on [DATE] at 5:15 pm with the New Facility ADM, she stated Resident #1 was comfortable when she did not move, but when staff had to reposition her or change her she was in excruciating pain and would yell out with tears in her eyes. New Facility was pre-medicating Resident #1 with pain medicine before having to reposition her but she was still in pain. The New Facility ADM stated that Resident #1 admitted with severe pain in her left hip and blanching and redness to her skin from a pressure injury to her coccyx.<br><br>During an interview on [DATE] at 12:36 pm LVN A stated that she answered a call light for the room next to Resident #1 and that resident heard a fall in the con-joined bathroom. LVN A found Resident #1 had fallen, urine was on the floor and her walker was folded against the door. She stated Resident #1 had a hematoma (swollen knot) to her right forehead and pain in her left arm. She stated the internet was down, so she could not see Resident #1's face sheet to notify the FM. She texted the DON that Resident #1 had an unwitnessed fall and a red raised area to the right front side of the head and complained of pain in her left shoulder with vitals bp ,d+[DATE], pulse 102, resp 18, O2 at 87 on room air (applied oxygen) and a temperature of 97.7. degrees Fahrenheit. The DON got the hospice provider's phone number and hospice was notified. Hospice stated they would notify the FM. LVN A initiated neuro checks on paper due to lack of access to the EHR. LVN A stated she administered the last tramadol to Resident #1 shortly after her fall and informed hospice that Resident #1 needed tramadol and lorazepam. LVN A left the paper to continue the neuro checks with RN A when LVN A's shift ended. RN A took over care of Resident #1 on [DATE] (day of fall) at 7:00 am.<br><br>During an interview on [DATE] at 11:30 am with RN A she stated that she administered tramadol to Resident #1 on the day of her fall ([DATE]) when prompted she said she would have put it in the MAR. She stated she entered x-ray that hospice doctor ordered on [DATE] and then called the x-ray company. RN A then stated that she was not working the day that the x-ray was ordered and that the DON called the x-ray company . RN A stated she did not remember if she performed neuro checks or not on Resident #1. RN A cared for Resident #1 on [DATE] - [DATE] (discharge). RN A was not able to answer all questions asked and when she answered she gave conflicting information multiple times.<br><br>Record review of Resident #1's [DATE] vitals revealed no blood pressure, respiratory rate, temperature, nor pulse entered by RN A on [DATE], [DATE], nor [DATE] (dates neuro checks should have been done).<br><br>Record review of Resident #1's discharge summary dated [DATE] at 2:28 pm created by RN A revealed Resident #1 was discharged to another facility on [DATE] at 2:54 pm.<br><br>Record review of Resident #1's [DATE] vitals revealed the following pain assessments:<br><br>-[DATE] 12:00 am level 4 entered by DON<br><br>-[DATE] 5:46 am level 4 entered by LVN A<br><br>-[DATE] 7:00 am level 3 entered by LVN A<br><br>(continued on next page) |

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F 0697

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

-[DATE] 7:32 am level 3 entered by LVN A

-[DATE] 8:31 am level 3 entered by LVN A

-[DATE] 11:38 am level 4 entered by RN A

-[DATE] 9:30 pm level 3 entered by LVN A

-[DATE] 1:36 am level 3 entered by LVN A

-[DATE] 8:17 pm level 7 entered by LVN F

-[DATE] 5:30 am level 3 entered by LVN A

-[DATE] 8:13 am level 0 entered by Former Employee

-[DATE] 9:25 pm level 8 entered by LVN F

-[DATE] 8:56 am level 6 entered by RN A

-[DATE] 9:00 am level 4 entered by the DON

Record review of Resident #1's 24- hour report for [DATE]-[DATE] revealed:

-[DATE] - no entry for Resident #1.

-[DATE] - Resident #1 showing increased confusion, no record of a fall entered by LVN A

-[DATE] - X-ray will be done tomorrow ([DATE]) for x-ray to left hip; fall on [DATE], x-ray ordered, and no tramadol entered by LVN F.

-[DATE] - blank, all entries reflected to see [DATE] entered by LVN F.

-[DATE] - Resident #1 7a-3p shift - neuro's, left at 3:00 pm, person who documented this did not fill out his/her name.

During an interview on [DATE] at 10:47 am with FAM stated Resident #1 was guarding her left arm and stated she was in pain at 2:00 pm on [DATE] when she visited. She stated she felt that Resident #1's cognition had a sharp decline after her fall on [DATE]; FAM arranged for Resident #1 to transfer to a different facility.

During an interview on [DATE] at 5:50 pm the DON she stated she was not at work [DATE], the day Resident #1 fell . She stated that tramadol was not in the hospice comfort kit and medication for hospice residents could not be pulled from the nexsys supply.

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on [DATE] at 11:35 am the Hospice Nurse stated that when she saw Resident #1 after the fall, she had a complete decline in function that was directly attributed to the fall. She stated she re-ordered pain medication for Resident #1 before the weekend of [DATE]-14th, so Resident #1 would not run out. She did not know why the medication did not arrive before [DATE]. She stated Resident #1 was in constant pain from the time of the fall and including the time she was admitted to the new facility. She said the new facility pre-medicated Resident #1 prior to moving her, but Resident #1 was still in pain unless she lies still.<br><br>Resident #2<br><br>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including acute post-procedural pain, spinal stenosis (narrowing of the spine), gout, and repeated falls.<br><br>Record review of Resident #2's annual MDS dated [DATE] revealed Resident #2 had a BIMS of 15, which indicated he was cognitively intact. It further revealed that Resident #2 had experience pain or hurting frequently in the past 5 days and that he had not experienced any falls since admission.<br><br>Record review of Resident #2's active orders for February 2024 revealed an order for Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE] mg, Give 2 tablet by mouth every 6 hours as needed for pain, with a start date of [DATE].<br><br>Record review of Resident #2's undated care plan revealed a focus of pain medication therapy, a goal of being free of discomfort or adverse side effects from pain medication and intervention of administer analgesic medication. It further revealed Resident #2 had an actual fall because his knee gave out (no date provided). It further revealed that Resident #2 was at high risk for falls. Further review revealed Resident #2 had acute/chronic pain with a goal of Resident #2 being able to verbalize adequate relief of pain or ability to cope with incompletely relieved pain, and intervention of anticipate need for pain relief and respond immediately to any complaint of pain.<br><br>Record review of the facility 802 form (a report of condition of residents including medications) printed on [DATE] revealed Resident #2 was on hypnotic (opiate not marked) and had a fall.<br><br>Record review of Resident #2's February 2024 MAR revealed the following pain medications administered at the following dates and times:<br><br>Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE] MG (Hydrocodone-Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for PAIN:<br><br>-[DATE] at 8:33 pm by LVN A<br><br>-[DATE] at 3:26 pm by RN C<br><br>-[DATE] at 12:53 pm by RN C<br><br>-[DATE] at 8:25 pm by LVN A<br><br>-[DATE] at 8:10 pm by LVN B<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Norco Oral Tablet ,d+[DATE] MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain:<br><br>-[DATE] at 7:47 pm by LVN A<br><br>-[DATE] at 7:22 pm by LVN A<br><br>Tylenol Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain:<br><br>-[DATE] at 7:38 am by RN C<br><br>Review of Resident #2's February 2024 progress note dated [DATE] at 7:38 am revealed a note entered by RN C that stated the resident had a level of pain 6 right now, waiting on triplicate from doctor.<br><br>During an interview on [DATE] at 3:45 pm with Resident #2, he stated that he was in pain because the facility was out of his hydrocodone. He said he was told his prescription expired and there was not a new one; he had been out of his hydrocodone for the last 3 days. He stated his pain went up to a 9 at nighttime, and the facility had run out of his medicine several times in the past, but this was the worst. He stated his pain was on average a 6 without his medicine and a 4 with his medicine. He said without his medicine he could not sleep due to the pain.<br><br>During an interview on [DATE] at 5:50 pm with the DON, she stated that last night ([DATE]) staff had checked that every resident in the facility had all of their pain medications available. She stated she only found out this morning ([DATE]) that Resident #2 was out of hydrocodone, and she stated his medication would be delivered this afternoon.<br><br>Record review of the 24-hour report for [DATE]-[DATE] revealed:<br><br>-[DATE] - Resident #2 - Norco re-ordered, complained of pain to right knee; written by LVN F<br><br>-[DATE] - Resident #2 - follow up on Norco, completely out; written by LVN F<br><br>During an interview on [DATE] at 10:15 am with the DON, she stated the harm of residents not receiving or having meds could lead to further illness/complications that may lead a resident to go to the hospital. Giving meds outside the parameters could cause further illness that may lead to serious medical conditions, and missing medications could lead to further complications/illness/ hospitalization s.<br><br>During an interview on [DATE] at 1:15 pm with the ADM, he stated the harm of not receiving medications could cause pain or further complications, and illnesses. Receiving medications outside parameters could cause more illness or result in infection.<br><br>Record review of the undated facility policy titled, Abuse, Neglect and Exploitation, in part, III. Prevention of abuse, neglect, and exploitation, the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect .identify and correct situations of neglect .assuring an assessment of resources needed to provide care and services to all residents .<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of the facility policy and procedure titled, Medication Administration undated revealed in part, 1. All medications are administered by licensed medical or nursing personnel as ordered by the physician and in accordance with professional standards .2.Compare the medication source with the MAR to verify dose and time .3.administer medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.<br><br>Record review of the undated facility policy titled, Pain Management and Treatment, revealed in part, 9. Obtaining pain medications . facility staff will ensure that pain medication is available to residents by the following methods:<br><br>a. Notify primary physician of need for refill and progress noted notification<br><br>b. When pain medicine is provided by Hospice, notify Hospice of need for refill and progress note notification .<br><br>d. if unable to obtain refill from hospice or primary notify the DON .<br><br>e. if a medication is needed it can be pulled from the nexsys system .<br><br>This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 2:36 PM. The ADM and DON were notified. The ADM and DON were provided with the IJ template on [DATE] at 4:15 PM.<br><br>The following plan of Removal submitted by the facility was accepted on [DATE] at 7:21 am:<br><br>Plan of Removal<br><br>The notification of Immediate jeopardy states as follows:<br><br>F697 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 residents' goals and preferences.<br><br>Resident #1 was admitted with terminal brain cancer and was left in pain after a fall.<br><br>Immediate Interventions :<br><br>1. Consultation and notification made to Medical Director, of Immediate Jeopardy on [DATE] at 4:45 pm by the DON. Ad Hoc QAPI meeting conducted with action plan developed on [DATE] attended by Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Nurse.<br><br>2. On [DATE] the DON and ADON were in-serviced, by Regional Nurse, on neglect, expectations in responding to X-Ray needs and timeliness of obtaining an X-Ray in the event of an injury and complaints of pain. The DON and ADON then in-serviced the licensed nursing staff to include, newly hired, PRN, and agency, on neglect, expectations in responding to X-Ray needs, timeliness of obtaining an X-Ray in the event of an injury, and complaints of pain on [DATE] and [DATE]. Staff not present will be in-serviced, by DON or designee, prior to next shift. Newly hired will be in-serviced, by DON or designee, upon hire prior to working on the floor. Agency and PRN will not be allowed to work on the floor until in-service and post-test is completed by DON or Designee.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 3. On 2/ ,d+[DATE] the DON and ADON were in-serviced, by Regional Nurse, on notification of medication refill needs, when medication card is at the blue on the medication card, or the medication is down to , d+[DATE] days of administration. The DON and ADON then in-serviced the licensed nursing staff to include, newly hired, PRN, and agency, on notification of medication refill needs, when medication card is at the blue on the medication card, or the medication is down to ,d+[DATE] days of administration. Staff not present will be in-serviced, by DON and ADON, prior to next shift. Newly hired will be in-serviced, by DON and ADON, upon hire, prior to working on the floor. Agency and PRN will not be allowed to work on the floor until in-service and post-test is completed by DON and ADON.<br><br>4. On [DATE] the DON, ADON, and 3 licensed nurses completed a pain assessment on all residents to identify any unmet pain needs or change in pain. Completed audit did not identify any unmet pain needs or change in pain. And an audit of medication availability for all residents on pain medications was also completed [DATE] by the ADON, Treatment Nurse, and Regional Nurse. The DON and ADON had oversight of the audit.<br><br>Monitoring:<br><br>1. The DON, ADON, or designee will review 24-hour report daily for any X-Ray orders to ensure timely follow up and intervention occurs. The Care plan will be updated at that time to reflect the intervention. This will be an ongoing monitoring system completed by the DON/ADON.<br><br>2. Administrator or designee, will review this process in the Clinical Meeting scheduled 5 times per week to monitor for compliance, and to make changes based on the interdisciplinary team's decision. This Process Review will be monitored for 12 weeks.<br><br>3. The facility's plan for pain management of new admits will be as follows:<br><br>a) If the resident is coming from home, DON or designee, will ask the resident's family to bring any medications that the resident is currently taking. If not possible, we revert to step c.<br><br>b) If the resident is coming from another nursing facility, DON or designee, will ask the DC facility to send the resident's current med supply. Also, if appropriate, DON or designee, will request the resident be given their medication before they discharge. If not possible, we revert to step c.<br><br>c) If the resident is DC from the hospital, DON or designee, will ask the hospital to medicate prior to discharge. Charge nurse will pull available medications from the nexsys system if necessary. If not available in the nexsys system, DON or designee, will call the PCP and order medications as substitutes until orders arrive. If we still do not have medications, and we cannot treat the resident as ordered, DON or designee, will call 911 and send them back to the hospital.<br><br>d) New admissions medication availability will be monitored, by DON and Administrator, during the morning clinical meeting during weekdays. On weekends, the medication availability will be monitored by the weekend supervisor.<br><br>MONITORING THE POR :<br><br>(continued on next page) |

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| | 675468 | A. Building<br>B. Wing | 03/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hico Nursing and Rehabilitation | 712 Railroad Ave<br>Hico, TX 76457 |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on [DATE] at 10:00 am with DON she stated the in-services were conducted 1 on 1 with each nursing staff and a post-test was conducted after. Testing conducted on abuse/neglect was just a refresher as the in-service was conducted back in January (so no post-test involved), Inservice on Pain medication orders/refills, post-fall x-ray protocol, and new admission medications along with post-tests was conducted. One LVN who had not been at work will test once she returns before the start of her shift. She and ADON will make sure the X-ray orders are reviewed for timeliness ongoing from here on out.<br><br>An observation on [DATE] at 10:45 am revealed residents gathered at the TV area. All appeared neat and well-groomed. All appeared pleasant and no one appeared distressed or ill. All appeared enjoying themselves.<br><br>During an interview and observation on [DATE] at 11:00 am Resident #2 he stated he was [NAME] today and just got out of bed. He stated that he felt safe, no pain at the moment, and he was safe and doing just fine. No issues or concerns. Observed neat and well-groomed sitting in his wheelchair in the room watching tv.<br><br>Record review of in-service sign-in sheets revealed the DON and ADON were in-serviced on [DATE] by the corporate nurse related to Pain medication orders/refills.<br><br>Record review of in-service sign-in sheets revealed on [DATE] the DON in-serviced staff related to pain medication orders/refills, which included a post-test.<br><br>Record review of in-service sign-in sheets revealed on [DATE] the DON and ADON in-serviced staff related to New Admission Medications and it was documented as completed and signed by RN B and LVN B.<br><br>During an interview on [DATE] at 12:45 pm with RN B she stated she was in-serviced on [DATE] one-to-one with DON along with a test after In-service on ordering narcotics, how to order x-rays for possible fractures, sending residents out for the hospital. Making sure medications are available to residents. Substitutions for mediation, in-service on abuse/neglect. Report to the abuse coordinator the administrator immediately if witnessed. Know the signs, gave examples of abuse/neglect Pain medications availability for residents. All the in-services were refresher training for her.<br><br>During an interview on [DATE] at 1:00 pm with LVN B in-service on [DATE] one-to-one with DON; in-services on medication errors, falling injury, new admits with mediations, In-service on abuse/neglect, know to report if ever witnessed abuse, coordinator is the administrator and the testing was completed after the in-services were conducted.<br><br>During an observation on [DATE] at 1:32 pm LVN D did a pain medication pass for Resident #7 and Resident #6 with no issues with med pass observed.<br><br>During an interview [DATE] at 2:25 pm with LVN C, who works the 7:00 am - 7:00 pm shift, she stated:<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | She was in serviced in the areas of pain management, falls, and abuse and neglect and new admission medications. She said an example of neglect is refusing to give a resident their medications or to feed them. The ADM is the abuse and neglect coordinator. She revealed the post fall x-ray in service instructed staff to enter information in EHR, call the company they contract with to do x-rays and if they are unavailable, to call 911 and have the resident transported to the hospital. Notify the RP, PCP, and if on Hospice, Hospice. If resident is on hospice, still notify the PCP. Make sure that the residents' pain medications are available and check availability. If pain medication is in pill form, and on a medication card, when the medication gets to the blue line, call to re-order to call hospice for renewal. If resident is on Hospice, make sure Hospice is informed about any need to obtain medication. If pain medication is needed, with a 2nd nurse, obtain from the electronic e-kit. If there are any problems, phone the DON. If there is a new resident admission get the medications from the family and check them against the PCP orders and place any needed pharmacy orders. If the resident comes from the hospital, ask the hospital to medicate prior to sending the resident to them. The charge nurse will put the medications in the electronic e-kit if needed. If they are not available in the electronic e-kit, the DON or will call the PCP and get medication substitutions.<br><br>During an interview on [DATE] at 2:20 pm with LVN D, who works 5 days a week 7:00 am - 3:00 pm shift, she stated:<br><br>She was in serviced on abuse and neglect - she said abuse is yelling at somebody and named the ADM as the abuse/neglect coordinator. She was in serviced on post fall x-ray protocol. The in service instructed to put the order PCC, call the x-ray contracting service and give them the order. If the contract service is unavailable, call the clinic or ER. When this is done notify DON, MD, ADM, and family. She was in serviced on new admission medications and told to get medications from the family until they get the pharmacy refills, if the resident is discharged from the hospital, ask the hospital to give all medications prior to coming to the facility, medications will be put into the electronic e-kit and if the resident needs a medication that is not in the e-kit, call the DON, family, and they will call the PCP and get substitutes until the facility gets the orders. When a resident has a pain medication, always be on the lookout to make sure they have enough medications. Let Hospice know of all refills needs. Communicate with Hospice. If you have to get a pain medication from the electronic e-kit, take a second nurse and obtain the medication. If you can't get a medication you need, call the DON.<br><br>During an interview on [DATE] at 2:58 pm with LVN E, who works 3:00 pm - 11:00 pm shift, she stated:<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | She was in serviced on pain management, x-rays, abuse and neglect, and new admission medication. She gave the examples of yelling at a resident as abuse and referring to a resident as a, feeder. She identified the ADM as the abuse and neglect coordinator. She said, with pain pills, when they are empty at the blue they need to be reordered. The important issue is to not let medications run out. Call Hospice if there are problems with the Hospice resident medications. With new residents, get medications from the family and if resident coming from the hospital, call the hospital and ask them to medicate resident prior to leaving the hospital. If a pain medication is not available, with a second nurse, get medications from the electronic e-kit system. If there is a problem getting a medication, call the DON. If a new resident does not have medications at the facility, call the DON and she will call their PCP to get a substitute medication until the residents prescription comes in. When an x-ray is needed, enter to necessary information into PCC and call the contract x-ray service. If they can't come, call EMS and send resident out. Always inform the RP, DON, and MD when a resident goes to the hospital. Always communicate with the DON and Hospice (if a Hospice resident) about medication needs and or issues.<br><br>During an interview on [DATE] at 1:15 pm with ADM he stated In-services with nursing staff were started on [DATE] with one LVN that had not been at work needing to be in-service. That in-service will take place before her next shift. In-service along with testing was conducted one to the Administrator verified and read off on all the in-services of nursing staff, Abuse/neglect in-service was conducted in regard to making sure x-rays conducted, medication availability, when to call medications in, and the effects of what the facility will do if medication not available. New residents admit as it relates to mediation how to handle if medications come from home or another facility or hospital. Pain management assessment on all residents was completed on [DATE] along with an audit of medication availability of all residents. The DON/ADON will review x-ray 24-report daily and the administrator will review daily for the next 12 weeks for each medication given. And make sure the new patient admission protocol is followed.<br><br>The ADM was informed the Immediate Jeopardy was removed on [DATE] at 3:15 p.m. The facility remained out of compliance at a scope of pattern with potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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** 46565<br><br>Based on 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 failed to provide a system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications for 2 (fridge and Hall 2) of 3 medication locations that were reviewed for pharmacy services, failed to reconcile narcotic sheets, and failed to ensure medications were given to residents within the prescribed times.<br><br>The facility failed to:<br><br>1. ensure narcotic sheets were filled out at shift change<br><br>2. reconciliation of narcotic sheets compared to MAR Resident #1 to ensure every narcotic that was signed out for Resident #1 was administered and documented as administered in the MAR<br><br>3. ensure the safe and timely administration of medications by RN A and Former Employee<br><br>These failures could place the residents at risk for not receiving the therapeutic effects from controlled narcotics due to not reconciling every shift, nor accounting for all narcotics signed out on the narcotics logs.<br><br>The findings included:<br><br>Record review of the form titled Controlled Drugs-Count Record for February 2024 for the fridge revealed missing signatures for the following dates: 2/1/24, 2/2/24, 2/5/24, 2/6/24, 2/7/24, 2/9/24, 2/10/24, 2/11/24, 2/12/24, and 2/13/24 - 2/22/24.<br><br>Review of the form for January 2024 for Hall 2 revealed missing signatures for the following dates: 1/4/24, 1/5/24, 1/6/24, 1/7/24, 1/13/24, 1/14/24, 1/18/24, 1/19/24.<br><br>During an interview on 02/23/24 at 5:50 pm with the DON, she stated that she reviewed all individual narcotic count sheets for completion, to ensure each narcotic sheet line was signed by the nurse. The DON stated she did not reconcile the narcotic count sheets against the MAR, and asked if she should. The DON stated she did not verify the correct number of pills or timing of the pills based on the order, she stated she did not and asked if she should.<br><br>Record review of the narcotic sheet and corresponding MAR for January 2024 for Resident #1's tramadol revealed the following dates on which tramadol was pulled based on the narcotic log, but no corresponding administration was found on the January 2024 MAR for the dates of 01/08/24 at 2:33 pm, 01/09/24 at 2:00 pm, and 01/13/24 at 4:00 pm all documented by RN A; and one documented by a different former staff member on 01/10/24 at 1:22 pm. Further review revealed the January 2024 MAR lacked an entry on the narcotic log on 01/07/24 11:29 am.<br><br>(continued on next page) |

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident #1

Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including syncope (fainting due to a decrease in blood flow to the brain), glaucoma (a condition where the eye's optic nerve is damaged), and abnormal brain scan.

Review of Resident #1's January 2024 orders revealed the following:

*Portable X-ray to left upper extremity. Maybe fractured after a fall. C/o lots of pain, dated 01/14/24.

*X-ray of left lower extremity(hip/pelvis) left upper extremity shoulder, left ribs dated 01/16/24.

*Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 4 hours as needed for pain dated 01/03/24.

*Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every morning and at bedtime for Pain related to NEOPLASM (cancer) OF UNSPECIFIED BEHAVIOR OF BRAIN dated 01/10/24.

* Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % Instill 1 drop in both eyes two times a day for Glaucoma dated 12/22/23

Review of Resident #1's Resident Information sheet in her admission packet, dated 12/13/23, reflected the FM as her emergency contact and responsibly party.

Review of Resident #1's admission MDS assessment, dated 12/20/23, reflected a BIMS (assessment of cognitive function) was not conducted. It further revealed Resident #1 received no intervention for pain. Review further revealed no falls since admission or prior to admission. Further review revealed Resident #1 required setup or cleanup assistance with toileting hygiene.

Review of Resident #1's undated care plan, reflected it had a focus of admission to hospice with a goal of keeping Resident #1 as comfortable as possible and intervention of administer pain medications as ordered and assess for verbal and non-verbal signs/symptoms of pain or discomfort all initiated on 12/14/23. Further review revealed the care plan had a focus dated 01/15/24, and reflected she had an actual fall with no serious injury due to unsteady gait with an intervention of having a PT consult for strength and mobility. An intervention of For no apparent acute injury, determine and address causative factors of the fall and it was initiated 01/17/24.

Resident #2

Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including acute post-procedural pain, spinal stenosis (narrowing of the spine), gout, and repeated falls.

Record review of Resident #2's annual MDS dated [DATE] revealed Resident #2 had a BIMS of 15, which indicated he was cognitively intact. It further revealed that Resident #2 had experience pain or hurting frequently in the past 5 days and that he had not experienced any falls since admission.

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #2's active orders for February 2024 revealed an order for:<br><br>-Hydrocodone-Acetaminophen Oral Tablet 5-325 mg, Give 2 tablet by mouth every 6 hours as needed for pain, with a start date of 01/17/24.<br><br>- Allopurinol Tablet 100 MG Give 1 tablet by mouth one time a day related to GOUT with a start date of 08/23/23<br><br>- Lisinopril Tablet 40 MG Give 40 mg by mouth one time a day related to hypertension (high blood pressure) with a start date of 08/23/23<br><br>- Omeprazole 20 MG Capsule delayed release Give 1 capsule by mouth one time a day related to GERD with a start date of 12/07/23<br><br>- Zyrtec Allergy Oral Tablet 10 MG Give 1 tablet by mouth one time a day for allergies with a start date of 08/23/23<br><br>- Isosorbide Mononitrate ER Oral Tablet Extended Release 24 Hour 30 MG Give 30 mg by mouth in the morning related to MYOCARDIAL INFARCTION (heart attack) with a start date of 12/08/23<br><br>- Ferrous Sulfate Oral Tablet 325 (65 Fe) MG Give 1 tablet by mouth two times a day related to anemia (low iron) with a start date of 10/26/23<br><br>- hydralazine HCl Oral Tablet 50 Give 1 tablet by mouth two times a day related to hypertension (high blood pressure) with a start date of 09/06/23<br><br>- Gabapentin Oral Capsule 300 MG Give 2 capsule by mouth three times a day related to restless leg syndrome (uncontrolled leg movements) with a start date of 03/24/23<br><br>Record review of Resident #2's undated care plan revealed a focus of pain medication therapy, a goal of being free of discomfort or adverse side effects from pain medication and intervention of administer analgesic medication. It further revealed Resident #2 had an actual fall because his knee gave out (no date provided). It further revealed that Resident #2 was at high risk for falls. Further review revealed Resident #2 had acute/chronic pain with a goal of Resident #2 being able to verbalize adequate relief of pain or ability to cope with incompletely relieved pain, and intervention of anticipate need for pain relief and respond immediately to any complaint of pain.<br><br>During a confidential interview, the person stated that because RN A performed so badly during the July 2023 full-book survey, the DON changed the medication administration times to make it easier for RN A to distribute medications without medication errors (despite all other nurses being able to administer medications in the appropriate times). The person further stated that despite the changes in the medication administration times, RN A was still not able to finish medication administration in the required times. Confidential person stated that RN A's screen on EHR showed residents that had medications not administered at the end of RN As shift and that residents had complained of late medications to confidential person.<br><br>(continued on next page) |

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of performance improvement plan for RN A dated 01/26/24 revealed the expectation that RN A be able to pass medication within the allotted time, increase critical thinking skills, verbalize issues with her residents when asked, and learn time management skills. Under areas of concern it stated RN A had difficulty administering medications in allotted time which caused medication errors, RN A had critical thinking skills that were in slow response to issues at hand, she lacked the ability to verbalize issues or knowledge of residents when asked, and had difficulty with time management. The goal for improvement in these areas was 30 days. The form was not signed by DON and nor was it signed by RN A.

During a confidential interview, a confidential resident stated that occasionally the resident's medication was administered late, especially by RN A, but the resident was able to go to the medication cart and request the necessary medication. Confidential resident said he/she had witnessed less mobile residents would get medication late occasionally as well but could not go to the cart to get their medications.

During an interview on 02/24/24 at 11:30 am with RN A she stated that most of the time she could give the medications to the residents in time. She said the DON had changed medication administration times a while back but she could not remember when. She said she was not given a performance improvement plan but had her annual evaluation last week and it mentioned her need to give medication within the allowed time. RN A was not able to answer all questions asked and when she answered she gave conflicting information multiple times.

During an interview on 02/23/24 at 5:50 pm with DON she stated that she forgot to give the performance improvement plan to RN A, upon which it was documented that RN A had medication errors due to inability to pass medication in the scheduled time; she further stated that several people had voiced concerns about RN A's competence in nursing including employees and the Medical Director of the facility. The DON denied changing the scheduled medication administration times for RN A and said she changed the times to make it easier for all nurses to administer medications without errors and to accommodate the needs of the residents.

Record review of the Medication Admin Audit Report for January 12 - 16, 2024 for Resident #1 revealed the following medication errors on her morning medications:

01/12/24 7:00 am Tramadol 50 mg administered 01/12/24 at 8:45 am by Former Employee.

01/13/24 8:00 am Dorzolamide Ophthalmic Solution (glaucoma eye drops) administered 01/13/24 9:53 am by RN A

01/14/24 8:00 am Dorzolamide Ophthalmic Solution (glaucoma eye drops) administered 01/14/24 11:41 am by RN A

01/16/24 7:00 am Tramadol 50 mg administered 01/16/24 8:13 am by Former Employee.

Record review of the Medication Admin Audit Report for January 12 - 16, 2024 for Resident #2 revealed the following medication errors on his medications:

01/12/24 7:00 am Allopurinol Tablet 100 MG administered 01/12/2024 at 10:14 am by Former Employee

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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 01/12/24 7:00 am Lisinopril Tablet 40 MG administered 01/12/2024 at 10:14 am by Former Employee<br><br>01/12/24 7:00 am Omeprazole 20 MG Capsule administered 01/12/2024 at 10:16 am by Former Employee<br><br>01/12/24 7:00 am Zyrtec Allergy Oral Tablet 10 MG administered 01/12/2024 at 10:16 am by Former Employee<br><br>01/12/24 8:00 am Isosorbide Mononitrate ER Oral Tablet administered 01/12/2024 at 9:55 am by Former Employee<br><br>01/12/24 8:00 am Ferrous Sulfate Oral Tablet administered 01/12/2024 at 9:54 am by Former Employee<br><br>01/12/24 8:00 am hydralazine HCl Oral Tablet 50 MG administered 01/12/2024 at 10:12 am by Former Employee 01/12/24 8:00 am Gabapentin Oral Capsule 300 MG administered 01/12/2024 at 10:13 am by Former Employee<br><br>01/13/24 7:00 am Allopurinol Tablet 100 MG administered 01/13/2024 at 9:32 am by RN A<br><br>01/13/24 7:00 am Lisinopril Tablet 40 MG administered 01/13/2024 at 9:32 am by RN A<br><br>01/13/24 7:00 am Omeprazole 20 MG Capsule administered 01/13/2024 at 9:33 am by RN A<br><br>01/13/24 7:00 am Zyrtec Allergy Oral Tablet 10 MG administered 01/13/2024 at 9:33 am by RN A<br><br>01/13/24 8:00 am Isosorbide Mononitrate ER Oral Tablet administered 01/13/2024 at 9:30 am by RN A<br><br>01/13/24 8:00 am Ferrous Sulfate Oral Tablet administered 01/13/2024 at 9:28 am by RN A<br><br>01/13/24 8:00 am hydralazine HCl Oral Tablet 50 MG administered 01/13/2024 at 9:28 am by RN A<br><br>01/13/24 8:00 am Gabapentin Oral Capsule 300 MG administered 01/13/2024 at 9:28 am by RN A<br><br>01/14/24 7:00 am Allopurinol Tablet 100 MG administered 01/14/2024 at 9:41 am by RN A<br><br>01/14/24 7:00 am Lisinopril Tablet 40 MG administered 01/14/2024 at 9:48 am by RN A<br><br>01/14/24 7:00 am Omeprazole 20 MG Capsule administered 01/14/2024 at 9:43 am by RN A<br><br>01/14/24 7:00 am Zyrtec Allergy Oral Tablet 10 MG administered 01/14/2024 at 9:43 am by RN A<br><br>01/14/24 8:00 am Isosorbide Mononitrate ER Oral Tablet administered 01/14/2024 at 9:30 am by RN A<br><br>01/14/24 8:00 am Ferrous Sulfate Oral Tablet administered 01/14/2024 at 9:48 am by RN A<br><br>01/14/24 8:00 am hydralazine HCl Oral Tablet 50 MG administered 01/14/2024 at 9:48 am by RN A<br><br>01/14/24 8:00 am Gabapentin Oral Capsule 300 MG administered 01/14/2024 at 9:37 am by RN A<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675468 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/07/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hico Nursing and Rehabilitation | 712 Railroad Ave<br>Hico, TX 76457 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 01/16/24 7:00 am Allopurinol Tablet 100 MG administered 01/16/2024 at 8:55 am by Former Employee<br><br>01/16/24 7:00 am Lisinopril Tablet 40 MG administered 01/16/2024 at 8:56 am by Former Employee<br><br>01/16/24 7:00 am Zyrtec Allergy Oral Tablet 10 MG administered 01/16/2024 at 8:55 am by Former Employee<br><br>Record review of the facility policy and procedure titled, Medication Administration undated revealed in part, 1. All medications are administered by licensed medical or nursing personnel as ordered by the physician and in accordance with professional standards .2.Compare the medication source with the MAR to verify dose and time .3.administer medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.<br><br>Review of the facility's undated policy titled Controlled Substance and Administration and Accountability revealed all controlled substances that are administered must be recorded on the designated usage form, clearly, legibly and with all required information .in all cases, the dose noted on the usage form must match the dose recorded on the Medication Administration Record (MAR). |