| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675495 | A. Building<br>B. Wing | 11/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Laurel Court | 3830 Mustang Road<br>Alvin, TX 77511 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the failed to ensure that its residents are free of any significant medication error for 1 (CR#1) of 5 residents reviewed for medication administration.CR#1 was ordered to receive 600 MG of Gabapentin in the evening for pain on 10/16/25 and 10/17/25 but was administered 300 MG both evenings by MA B.MA B failed to follow physician orders or consult with a nurse for order clarification.These failures could place residents at risks for increased pain, discomfort, and a diminished quality of life.Findings include: Record review of CR#1's face-sheet reviewed 10/21/25, revealed a seventy-six year old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were a Type II Dens fracture (a break in the odontoid process, the peg-like structure that connects the second vertebra (axis) to the first vertebra (atlas) in the cervical spine), elevated white blood cell count, cervicalgia (pain in the neck region), pain, and adult failure to thrive. Record review of CR#1's Pain Management Team Encounter notes dated 10/16/25 stated that she was AAO x2-3. CR#1 had unspecified pain and treatment goals were directly therapeutic and were incorporated to provide improvement and/or prevention of progression of the condition, while providing a reasonable expectation of recovery. Record Review of CR#1's care plan reviewed 10/21/25, displayed a focus on pain management initiated on 10/16/25. Interventions stated to screen for pain on admission and daily. Assess to determine if experiencing pain. If pain was present, conduct, and document pain assessment particularly location, nature, intensity, and duration of pain. Record review of CR#1's orders dated 10/15/25 documented that CR#1 was to receive: 1. Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for nerve pain. 2. Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for nerve pain equals 600mg for AM and PM doses. Record review of CR#1's MAR dated October 2025 revealed the medications were administered as follows: 1- 300MG Gabapentin capsule by mouth two times a day (a.m. and p.m. doses that equaled 600 MG) for nerve pain. * 10/16/25 at 9:00 a.m. dose was marked administered by MA A *10/16/25 at 9:00 p.m. dose was marked administered by MA B. *10/17/25 at 9:00 a.m. dose was marked administered by MA A *10/17/25 at 9:00 p.m. doses was marked administered by MA B. * 10/18/25 at 9:00 a.m., dose was marked administered by the ADON. 1- 300 MG Gabapentin capsule to be given by mouth three times a day for nerve pain. *10/16/25 at 9:00 a.m. dose was marked administered by MA A, *10/16/25 at 3:00 p.m. and the 9:00 p.m. doses were marked administered by MA B. *10/17/25 at 9:00 a.m. dose was marked administered by MA A *10/17/25 at 3:00 p.m. and the 9:00 p.m. doses were marked administered by MA B *10/18/25 at 9:00 a.m., was marked administered by the ADON. In total, 5 Gabapentin 300 MG capsules should be administered to CR#1 daily and a total of 12 capsules should have been administered from 10/16/25 to 10/18/25 at 9:00 a.m. Record review of CR#1's progress notes on 10/18/25 at 11:42 a.m. inputted by ADON stated CR#1 had a change in condition where she was unresponsive. Nursing observation documented: ADON was called to room due to change in condition. NP notified and orders given to send out via 911 to hospital for further evaluation. Resident left with EMS at 11:54 a.m. via stretcher. In an interview and observation on 10/21/25 at 12:14 p.m., MA A, stated she worked at the facility since 2020 and had stepped into the role as a medication aide in March 2025. She worked from 6 a.m. to 2 p.m. and only remembered giving medications to CR#1 twice. She explained when she gave medication, she would verify the orders by checking the resident's name with the picture, asking the resident to verify their first and last name, and making sure the blister pack matched the orders. MA A took the Surveyor to the medication cart and she reviewed CR #1's orders. She stated she saw there was one order to give 1 tab of 300 MG of Gabapentin 3xs a day and another to give 1 tab of 300 MG of Gabapentin 2xs a day. On her shift of 6 a.m. to 2 p.m., she was ordered to give CR#1 2 capsules of Gabapentin. Reviewing the time stamps in the MAR, she administered this medication on 10/16/25 at 10:34 a.m. and on 10/17/25 at 10:22 a.m. She stated although she saw two separate orders in the MAR, she did not feel like it was inputted by accident, and she followed the orders as written. MA A stated she did not notice any adverse effects or any changes in her behavior. She explained that if she suspected there was an overlap in medications or a discrepancy, she would consult with one of the nurses. Inside the medication cart, there was one bottle of Gabapentin 300 MG filled on 10/15/25 for 60 capsules for CR#1. A blister pack was also found for Gabapentin 300 MG filled on 10/16/25 for 70 capsules. MA A recalled that she administered medication from the Gabapentin bottle initially, but she switched over to the blister pack once it was delivered on 10/17/25. MA A counted the amount of medication remaining from both the pack and the bottle that equaled a total of |