

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/27/2025
NAME OF PROVIDER OR SUPPLIER  Sugar Land Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  333 Matlage Way Sugar Land, TX 77478	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide services that met professional standards of quality for 2 of 15 residents (Residents #55 and #24) reviewed for services.</p> <p>1.</p> <p>Resident #55 failed to receive nine medications he was ordered to receive on 2/2/2025.</p> <p>2.</p> <p>Resident #24 did not receive one medication 41 times from 04/20/2025 to 05/07/2025.</p> <p>These failures could place residents at risk of worsening of illnesses and not receiving the therapeutic dosage.</p> <p>Findings included:</p> <p>Resident #55</p> <p>Record review of Resident #55's face sheet, he was an [AGE] year-old male originally admitted on [DATE] at 4:45 p.m. and discharged [DATE] to home. His medical diagnoses included metabolic encephalopathy (brain disorder caused by the body's metabolic processes and lead to impaired brain function), hyperlipidemia (high levels of fat in the blood), chronic inflammatory demyelinating polyneuritis (a rare neurological disorder affecting the nerves and nerve roots and leading to weakness and paired motor function), fracture of the first lumbar vertebra (lower spine fracture), and muscle weakness.</p> <p>Record review of Resident #55's functional performance assessment dated [DATE], revealed he was dependent on a helper for activities.</p> <p>Record review of Resident #55's care plan dated 2/2/2025 revealed he was on anticoagulant therapy with interventions including administering anticoagulant medications as ordered by physician and monitor for side effects and effectiveness. Resident #55 was on anticonvulsant medication, with interventions including administering anticonvulsant medications as prescribed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #55's progress notes from admission to discharge revealed Resident #55 was admitted on [DATE] at 4:45pm and discharged [DATE] around 3pm. On 2/2/25 at 2:24pm, RN A documented that all scheduled medicines were not received from the pharmacy and that she called the pharmacy to send the medications before 4pm but the pharmacy relayed the earliest the delivery could come was 5pm. The RP said they were leaving the facility. RN A informed the NP and ADON but did not state what she told them. The notes did not state the reason why Resident #55 did not receive his medications.</p> <p>Record review of Resident #55's Physician Orders, he was prescribed the following with start dates of 2/2/25:</p> <ul style="list-style-type: none"> <li>*Amiodarone Hcl Oral Tablet 200 Mg 1 tablet a day for arrythmia (irregular heart beat),</li> <li>*Apixaban oral Tablet 1 tablet twice a day to prevent blood clots, Observation for anticoagulant/antiplatelet medication side effects such as blood in urine and coughing up blood,</li> <li>*Metoprolol Succinate ER oral Tablet Extended Release 24 Hour 25 MG one tablet one time a day for hypertension,</li> <li>*Cyanocobalamin Oral Tablet 1000MCG one tablet one time a day for vitamin supplement,</li> <li>*Duloxetine HCl Oral Capsule Delayed Release Sprinkle 30 MG 3 capsules one time a day for depression,</li> <li>*Fludrocortisone Acetate Oral Tablet 1 MG give 1 tablet by mouth one time a day related to inflammatory demyelinating polyneuritis for pain in the nerves,</li> <li>*Finasteride Oral Tablet 5 MG 1 tablet one time a day for BPH (enlarged prostate gland which affects urination),</li> <li>*Phenazopyridine HCl 1 tablet three times a day for burning sensation in the urinary tract,</li> <li>*Primidone Oral Tablet 50 MG 2 tablets one time a day for convulsion, and</li> <li>*Thiamine HCl Oral Tablet 100 MG 1 tablet a day for supplement.</li> </ul> <p>Record review of Resident #55's February 2025 MAR (medication administration record) revealed the following medications were documented as not administered as ordered on 2/2/25:</p> <ul style="list-style-type: none"> <li>*Amiodarone at 9am,</li> <li>*Apixaban for 9am and 5pm,</li> <li>*Metoprolol at 9am,</li> <li>*Cyanocobalamin at 9am,</li> <li>*Duloxetine HCl Oral Tablet at 9am,</li> </ul> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Fludrocortisone Acetate Oral Tablet at 9am,</p> <p>*Finasteride Oral Tablet at 9am,</p> <p>*Primidone at 9am,</p> <p>*Phenazopyridine HCl Oral Tablet at 9am and 2pm, and</p> <p>*Thiamine HCl Oral Tablet at 9am.</p> <p>On 2/2/25 at 6am, Resident #55 was observed with no side effects of anticoagulant/antiplatelet medication including coughing blood and severe bruising. His vitals including his BP, temperature, pulse and oxygen were within normal limits. Resident #55's pain level was at a 1.</p> <p>Record review of the facility's in-service dated 2/3/2025 on the topic of med aides reporting to charge nurses for any abnormalities regarding missing medications. CMA A and RN A. There was a blank form titled Medication Request with nurses documenting medication aide requesting medications and how many medications a resident has left.</p> <p>Interview on 5/7/2025 at 11:42am with CMA A, she did not remember Resident #55 or the resident not getting any medications. CMA A's job duties included administering scheduled medications and over-the-counters except antibiotics and requesting refills from the pharmacy. When medications were not available, she would tell her nurses so they could get medications from emergency kit and the nurses would also call the pharmacy for follow-up on medication status.</p> <p>Interview on 5/7/2025 at 11:59am with RN A on 5/7/2025 at 12:50pm, she said if a new admission was coming from hospital, she would check the medication administration list. She would verify the medications with the NP, then upload the orders into the resident record. She would ask the NP about medications to confirm which medications would be continued. The person who accepted the resident would send the medication list to the pharmacy, but the assessing nurse could send it as well. Before 5:30pm, nurses could upload the medication list and call the pharmacy. If medications have not received by 5:30pm, nurses would fax and call the pharmacy about the medications to be sent before 12:00pm. RN A stated on 2/1/25 she uploaded the medication list to the pharmacy. RN A called the ADON who told her the facility could not borrow medications from the e-kit. RN A called the pharmacy late on 2/1/25 around 5pm to send the medication list. RN A said the resident did miss his doses but that day the resident was fine. RN A said if Resident #55 missed his Apixaban that could cause him to go into shock, if he missed his Amiodarone, he could have a faster heart rate, and if he missed his Metoprolol, he could have an episode of hypertension. She called the ADON and Administrator and informed them both that Resident #55 and his family left.</p> <p>Interview on 5/7/2025 at 12:04 with LVN A, she said she was helping that weekend as a supervisor. LVN A recalled talking to Resident #55's RP and tried to assure her the facility could get medications from the emergency kit (a machine in which nursing staff could access medications for a resident with a code from the pharmacy), but the family refused. She said RN A was the nurse on duty. She said she did not look into the issue because RN A talked to the DON about the situation already. She said a risk to residents if they did not get Apixaban could be they go into shock. If the resident did not receive Amiodarone, it could increase their heart rate and if they missed a dose of Metoprolol, it could affect their blood pressure and the resident could go into shock.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 5/7/25 at 12:50pm with RN B/previous ADON, said if she was a resident's admitting nurse she would call the NP and reconcile the medication, then send it to the pharmacy to get it in before closing time. Then she would put the medication in the orders. If medications have not arrived, she would contact the hospital or call the pharmacy, then let the DON know and go to the e-kit. She would call the pharmacy for emergency deliveries and let the DON know. The pharmacy usually came once a day at 7pm but RN B said they have delivered at other times. She was not at the facility at the time of Resident #55's discharge but heard there was a miscommunication between medication aides and nurses. The nurses said the medication aides did not tell them right away about the medications not being in there, but when the nurse found out they called the pharmacy. She found this out on 2/3/25 as she was off. The facility did in services about communicating missing medications from medication aides to nurses. The nurses were in serviced to check on new admissions and if medications were in the facility. She did not talk to the pharmacy or family. If Resident #55 missed Apixaban, Amiodarone and Metoprolol he could have had a stroke.</p> <p>Interview on 5/7/25 at 12:57pm with the DON, he said when a new admission comes it, their medications should be verified right away and given timely. Medications should be given following Physician Orders. The DON said narcotics could be delayed but that staff could get the medications from the emergency kit while they send in an order request to the resident's doctor. If medications were not at the facility, the nurses could contact the pharmacy. The DON remembered Resident #55 was supposed to get a narcotic medication and Resident #55's family got upset that the medications did not arrive and chose to discharge Resident #55 home. The DON said it was a miscommunication issue due to CMA A not communicating with RN B that the medication was not there. The family refused to speak to the DON afterward. The DON said if Resident #55 missed Apixaban he could have bleeding, if he missed his Amiodarone, he could have elevated heart issues or hypertension, and if Resident #55 missed his Metoprolol he would be at risk of heart issues.</p> <p>Interview on 5/8/2025 at 4:25pm the DON said that Atorvastatin controlled lipids, and Phenazopyridine, Thiamine, Finasteride, Ergocalciferol, Duloxetine, and Cyanocobalamin were missed medication. He said the medications treated conditions, but that Resident #55 was not at any risk from missing those medications because the medications were being delivered that day. He said nurses ensured aides provided medications. He said the NP was notified of the missing medications. Most of the residents' medications would not have been in the e-kit which usually contained steroids.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 5/7/2025 at 1:22pm with the Administrator, her expectation of nurses following a resident's new admission and their medication is to follow up with the pharmacy and physician and check in with DON and Administrator. Upon admissions, if resident did not have their medication, the facility could contact the physician and get it from the e-kit or contact the pharmacy to get a stat run (prioritized delivery). The Administrator said on weekends which was when Resident #55 was admitted, the cut-off would be 3pm for orders for a 5pm delivery. Facility staff could also access an online health portal to access medications from an on-call physician. The Administrator said she spoke to the pharmacy on 2/2/25 around 1pm, and they informed her Resident #55's medication was on the way, but the family said he wanted to leave. If Resident #55 missed Apixaban, it is for clotting and the risk of not giving the medication was clotting and clots could travel to the heart and cause heart attaches or travel to the brain, and Amiodarone she said he would still be able to get a dose if it came in later 5pm it would not have affected him, but signs and symptoms should be monitored. If Resident #55 did not get the Metoprolol, it could have affected his blood pressure but his vitals for blood pressure was normal that day. It would have been preferred if the medication was given in the morning, but the facility had 24 hours to get Resident #55 his daily medications. She said medication should be given one hour before or after a scheduled dose. The Administrator said the NP was notified medications were missing.</p> <p>Interview with NP A on 5/7/2025 at 1:51pm, she said she did the admission process including receiving and verifying Resident #55's physician orders and medications for Resident #55 and remembered meeting with Resident #55's family on 2/1/25. NP A said the facility called her on 2/2/25 to inform her that Resident #55 was leaving. She asked to speak to the family, but they had already left, and she was told they left because his medications had not come. She said the facility nurses would have submitted medications onto the online portal for the pharmacy. NP A was not notified Resident #55 missed medications on 2/2/25. If the facility had told her, NP A would have called the pharmacy herself. Apixaban could have caused a blood clot but if he was taking it daily if he missed a 24-hour dose he would have been okay, same with Amiodarone and she does not like medications to be delayed but it's okay and not risk. If Resident #55 missed Metoprolol, the facility should have checked his blood pressure, but if they had missed it, it could affect his blood pressure. If Resident #55 had high blood pressure, and the facility informed NP A, she would have sent an order from the emergency kit. She stated if Resident #55's Fludrocortisone was delayed, he could have more pain. She said that per state law, medications can be given 1-2 hours before or after the scheduled time.</p> <p>Resident #24</p> <p>Record review of the admission Record for Resident #24 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Stage 5 kidney disease (end stage kidney disease), anemia in chronic kidney disease, history of cancer of the kidney, acquired absence of kidney, and dependence on renal dialysis.</p> <p>Record review of Resident #24's Care Plan (revised 03/02/2025) revealed he required hemodialysis due to renal (kidney) failure. The hemodialysis section of the Care Plan did not address medications.</p> <p>Record review of Resident #24's Care Plan section initiated on 05/07/2025 reflected the resident could become hypotensive (low blood pressure). One intervention read, in part, .Give medications as ordered. Monitor for side effects and effectiveness.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #24's Physician's Order dated 04/01/2025 revealed he was to receive Sevelamer Carbonate 800 mg tablet (2) tablets with meals (3 times per day).</p> <p>Record review of Resident #24's April 2025 MAR revealed the resident's Sevelamer Carbonate 800 mg tablets (2) were not administered for two of the three opportunities on the following dates:</p> <p>04/20/2025 12:00 p.m. and 5:00 p.m. doses</p> <p>04/23/2025 12:30 p.m. and 9:00 p.m. doses</p> <p>04/28/2025 07:30 a.m. and 12:30 p.m. doses</p> <p>04/30/2025 07:30 a.m. and 12:30 p.m. doses</p> <p>(8 missed doses).</p> <p>The Sevelamer Carbonate 800 mg tablets (2) were not administered for three of the three opportunities on the following dates:</p> <p>04/21/2025 07:30 a.m., 12:30 p.m., and 9:00 p.m.</p> <p>04/22/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>04/24/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>04/26/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>04/27/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>04/29/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>(18 missed doses).</p> <p>Record review of Resident #24's May 2025 MAR revealed the resident's Sevelamer Carbonate 800 mg tablets (2) were not administered for one of one opportunity on the following date:</p> <p>05/06/2025 07:00 a.m.</p> <p>(1 missed dose)</p> <p>The resident was out of the facility for the 12:00 p.m. and 5:00 p.m. scheduled doses.</p> <p>Record review of Resident #24's May 2025 MAR revealed the resident's Sevelamer Carbonate 800 mg tablets (2) were not administered for two of the three opportunities on the following dates:</p> <p>05/02/2025 07:30 a.m. and 12:30 p.m.</p> <p>05/05/2025 07:30 a.m. and 12:30 p.m.</p> <p>(continued on next page)</p>

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide routine and emergency drugs and biologicals to its residents and 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 for 2 of 15 (Residents #55 and #24) reviewed for medication administration.</p> <p>1.</p> <p>Resident #55 did not receive nine medications as ordered by the Physician on 2/2/2025.</p> <p>2.</p> <p>Resident #24 did not receive one medication 41 times from 04/20/2025 to 05/07/2025.</p> <p>This failure could lead to a decline in residents' physical, mental and emotional health due to not receiving the medications and the therapeutic effects to treat their conditions as ordered by their physician.</p> <p>Findings included:</p> <p>Resident #55</p> <p>Record review of Resident #55's face sheet, he was an [AGE] year-old male originally admitted on [DATE] at 4:45 p.m. and discharged [DATE] to home. His medical diagnoses included metabolic encephalopathy (brain disorder caused by the body's metabolic processes and lead to impaired brain function), hyperlipidemia (high levels of fat in the blood), chronic inflammatory demyelinating polyneuritis (a rare neurological disorder affecting the nerves and nerve roots and leading to weakness and paired motor function), fracture of the first lumbar vertebra (lower spine fracture), and muscle weakness.</p> <p>Record review of Resident #55's functional performance assessment dated [DATE], revealed he was dependent on a helper for activities.</p> <p>Record review of Resident #55's care plan dated 2/2/2025 revealed he was on anticoagulant therapy with interventions including administering anticoagulant medications as ordered by physician and monitor for side effects and effectiveness. Resident #55 was on anticonvulsant medication, with interventions including administering anticonvulsant medications as prescribed.</p> <p>Review of Resident #55's progress notes from admission to discharge revealed Resident #55 was admitted on [DATE] at 4:45pm and discharged [DATE] around 3pm. On 2/2/25 at 2:24pm, RN A documented that all scheduled medicines were not received from the pharmacy and that she called the pharmacy to send the medications before 4pm but the pharmacy relayed the earliest the delivery could come was 5pm. The RP said they were leaving the facility. RN A informed the NP and ADON but did not state what she told them. The notes did not state the reason why Resident #55 did not receive his medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #55's Physician Orders, he was prescribed the following with start dates of 2/2/25:</p> <ul style="list-style-type: none"> <li>*Amiodarone Hcl Oral Tablet 200 Mg 1 tablet a day for arrythmia (irregular heart beat),</li> <li>*Apixaban oral Tablet 1 tablet twice a day to prevent blood clots, Observation for anticoagulant/antiplatelet medication side effects such as blood in urine and coughing up blood,</li> <li>*Metoprolol Succinate ER oral Tablet Extended Release 24 Hour 25 MG one tablet one time a day for hypertension,</li> <li>*Cyanocobalamin Oral Tablet 1000MCG one tablet one time a day for vitamin supplement,</li> <li>*Duloxetine HCl Oral Capsule Delayed Release Sprinkle 30 MG 3 capsules one time a day for depression,</li> <li>*Fludrocortisone Acetate Oral Tablet 1 MG give 1 tablet by mouth one time a day related to inflammatory demyelinating polyneuritis for pain in the nerves,</li> <li>*Finasteride Oral Tablet 5 MG 1 tablet one time a day for BPH (enlarged prostate gland which affects urination),</li> <li>*Phenazopyridine HCl 1 tablet three times a day for burning sensation in the urinary tract,</li> <li>*Primidone Oral Tablet 50 MG 2 tablets one time a day for convulsion, and</li> <li>*Thiamine HCl Oral Tablet 100 MG 1 tablet a day for supplement.</li> </ul> <p>Record review of Resident #55's February 2025 MAR (medication administration record) revealed the following medications were documented as not administered as ordered on 2/2/25:</p> <ul style="list-style-type: none"> <li>*Amiodarone at 9am,</li> <li>*Apixaban for 9am and 5pm,</li> <li>*Metoprolol at 9am,</li> <li>*Cyanocobalamin at 9am,</li> <li>*Duloxetine HCl Oral Tablet at 9am,</li> <li>*Fludrocortisone Acetate Oral Tablet at 9am,</li> <li>*Finasteride Oral Tablet at 9am,</li> <li>*Primidone at 9am,</li> <li>*Phenazopyridine HCl Oral Tablet at 9am and 2pm, and</li> </ul> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Thiamine HCl Oral Tablet at 9am.</p> <p>On 2/2/25 at 6am, Resident #55 was observed with no side effects of anticoagulant/antiplatelet medication including coughing blood and severe bruising. His vitals including his BP, temperature, pulse and oxygen were within normal limits. Resident #55's pain level was at a 1.</p> <p>Record review of the facility's in-service dated 2/3/2025 on the topic of med aides reporting to charge nurses for any abnormalities regarding missing medications. CMA A and RN A. There was a blank form titled Medication Request with nurses documenting medication aide requesting medications and how many medications a resident has left.</p> <p>Interview on 5/7/2025 at 11:42am with CMA A, she did not remember Resident #55 or the resident not getting any medications. CMA A's job duties included administering scheduled medications and over-the-counters except antibiotics and requesting refills from the pharmacy. When medications were not available, she would tell her nurses so they could get medications from emergency kit and the nurses would also call the pharmacy for follow-up on medication status.</p> <p>Interview on 5/7/2025 at 11:59am with RN A on 5/7/2025 at 12:50pm, she said if a new admission was coming from hospital, she would check the medication administration list. She would verify the medications with the NP, then upload the orders into the resident record. She would ask the NP about medications to confirm which medications would be continued. The person who accepted the resident would send the medication list to the pharmacy, but the assessing nurse could send it as well. Before 5:30pm, nurses could upload the medication list and call the pharmacy. If medications have not received by 5:30pm, nurses would fax and call the pharmacy about the medications to be sent before 12:00pm. RN A stated on 2/1/25 she uploaded the medication list to the pharmacy. RN A called the ADON who told her the facility could not borrow medications from the e-kit. RN A called the pharmacy late on 2/1/25 around 5pm to send the medication list. RN A said the resident did miss his doses but that day the resident was fine. RN A said if Resident #55 missed his Apixaban that could cause him to go into shock, if he missed his Amiodarone, he could have a faster heart rate, and if he missed his Metoprolol, he could have an episode of hypertension. She called the ADON and Administrator and informed them both that Resident #55 and his family left.</p> <p>Interview on 5/7/2025 at 12:04 with LVN A, she said she was helping that weekend as a supervisor. LVN A recalled talking to Resident #55's RP and tried to assure her the facility could get medications from the emergency kit (a machine in which nursing staff could access medications for a resident with a code from the pharmacy), but the family refused. She said RN A was the nurse on duty. She said she did not look into the issue because RN A talked to the DON about the situation already. She said a risk to residents if they did not get Apixaban could be they go into shock. If the resident did not receive Amiodarone, it could increase their heart rate and if they missed a dose of Metoprolol, it could affect their blood pressure and the resident could go into shock.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 5/7/25 at 12:50pm with RN B/previous ADON, said if she was a resident's admitting nurse she would call the NP and reconcile the medication, then send it to the pharmacy to get it in before closing time. Then she would put the medication in the orders. If medications have not arrived, she would contact the hospital or call the pharmacy, then let the DON know and go to the e-kit. She would call the pharmacy for emergency deliveries and let the DON know. The pharmacy usually came once a day at 7pm but RN B said they have delivered at other times. She was not at the facility at the time of Resident #55's discharge but heard there was a miscommunication between medication aides and nurses. The nurses said the medication aides did not tell them right away about the medications not being in there, but when the nurse found out they called the pharmacy. She found this out on 2/3/25 as she was off. The facility did in services about communicating missing medications from medication aides to nurses. The nurses were in serviced to check on new admissions and if medications were in the facility. She did not talk to the pharmacy or family. If Resident #55 missed Apixaban, Amiodarone and Metoprolol he could have had a stroke.</p> <p>Interview on 5/7/25 at 12:57pm with the DON, he said when a new admission comes it, their medications should be verified right away and given timely. Medications should be given following Physician Orders. The DON said narcotics could be delayed but that staff could get the medications from the emergency kit while they send in an order request to the resident's doctor. If medications were not at the facility, the nurses could contact the pharmacy. The DON remembered Resident #55 was supposed to get a narcotic medication and Resident #55's family got upset that the medications did not arrive and chose to discharge Resident #55 home. The DON said it was a miscommunication issue due to CMA A not communicating with RN B that the medication was not there. The family refused to speak to the DON afterward. The DON said if Resident #55 missed Apixaban he could have bleeding, if he missed his Amiodarone, he could have elevated heart issues or hypertension, and if Resident #55 missed his Metoprolol he would be at risk of heart issues.</p> <p>Interview on 5/8/2025 at 4:25pm the DON said that Atorvastatin controlled lipids, and Phenazopyridine, Thiamine, Finasteride, Ergocalciferol, Duloxetine, and Cyanocobalamin were missed medication. He said the medications treated conditions, but that Resident #55 was not at any risk from missing those medications because the medications were being delivered that day. He said nurses ensured aides provided medications. He said the NP was notified of the missing medications. Most of the residents' medications would not have been in the e-kit which usually contained steroids.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 5/7/2025 at 1:22pm with the Administrator, her expectation of nurses following a resident's new admission and their medication is to follow up with the pharmacy and physician and check in with DON and Administrator. Upon admissions, if resident did not have their medication, the facility could contact the physician and get it from the e-kit or contact the pharmacy to get a stat run (prioritized delivery). The Administrator said on weekends which was when Resident #55 was admitted, the cut-off would be 3pm for orders for a 5pm delivery. Facility staff could also access an online health portal to access medications from an on-call physician. The Administrator said she spoke to the pharmacy on 2/2/25 around 1pm, and they informed her Resident #55's medication was on the way, but the family said he wanted to leave. If Resident #55 missed Apixaban, it is for clotting and the risk of not giving the medication was clotting and clots could travel to the heart and cause heart attaches or travel to the brain, and Amiodarone she said he would still be able to get a dose if it came in later 5pm it would not have affected him, but signs and symptoms should be monitored. If Resident #55 did not get the Metoprolol, it could have affected his blood pressure but his vitals for blood pressure was normal that day. It would have been preferred if the medication was given in the morning, but the facility had 24 hours to get Resident #55 his daily medications. She said medication should be given one hour before or after a scheduled dose. The Administrator said the NP was notified medications were missing.</p> <p>Interview with NP A on 5/7/2025 at 1:51pm, she said she did the admission process including receiving and verifying Resident #55's physician orders and medications for Resident #55 and remembered meeting with Resident #55's family on 2/1/25. NP A said the facility called her on 2/2/25 to inform her that Resident #55 was leaving. She asked to speak to the family, but they had already left, and she was told they left because his medications had not come. She said the facility nurses would have submitted medications onto the online portal for the pharmacy. NP A was not notified Resident #55 missed medications on 2/2/25. If the facility had told her, NP A would have called the pharmacy herself. Apixaban could have caused a blood clot but if he was taking it daily if he missed a 24-hour dose he would have been okay, same with Amiodarone and she does not like medications to be delayed but it's okay and not risk. If Resident #55 missed Metoprolol, the facility should have checked his blood pressure, but if they had missed it, it could affect his blood pressure. If Resident #55 had high blood pressure, and the facility informed NP A, she would have sent an order from the emergency kit. She stated if Resident #55's Fludrocortisone was delayed, he could have more pain. She said that per state law, medications can be given 1-2 hours before or after the scheduled time.</p> <p>Resident #24</p> <p>Record review of the admission Record for Resident #24 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Stage 5 kidney disease (end stage kidney disease), anemia in chronic kidney disease, history of cancer of the kidney, acquired absence of kidney, and dependence on renal dialysis.</p> <p>Record review of Resident #24's Care Plan (revised 03/02/2025) revealed he required hemodialysis due to renal (kidney) failure. The hemodialysis section of the Care Plan did not address medications.</p> <p>Record review of Resident #24's Care Plan section initiated on 05/07/2025 reflected the resident could become hypotensive (low blood pressure). One intervention read, in part, .Give medications as ordered. Monitor for side effects and effectiveness.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #24's Physician's Order dated 04/01/2025 revealed he was to receive Sevelamer Carbonate 800 mg tablet (2) tablets with meals (3 times per day).</p> <p>Record review of Resident #24's April 2025 MAR revealed the resident's Sevelamer Carbonate 800 mg tablets (2) were not administered for two of the three opportunities on the following dates:</p> <p>04/20/2025 12:00 p.m. and 5:00 p.m. doses</p> <p>04/23/2025 12:30 p.m. and 9:00 p.m. doses</p> <p>04/28/2025 07:30 a.m. and 12:30 p.m. doses</p> <p>04/30/2025 07:30 a.m. and 12:30 p.m. doses</p> <p>(8 missed doses ).</p> <p>The Sevelamer Carbonate 800 mg tablets (2) were not administered for three of the three opportunities on the following dates:</p> <p>04/21/2025 07:30 a.m., 12:30 p.m., and 9:00 p.m.</p> <p>04/22/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>04/24/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>04/26/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>04/27/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>04/29/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>(18 missed doses).</p> <p>Record review of Resident #24's May 2025 MAR revealed the resident's Sevelamer Carbonate 800 mg tablets (2) were not administered for one of one opportunity on the following date:</p> <p>05/06/2025 07:00 a.m.</p> <p>(1 missed dose)</p> <p>The resident was out of the facility for the 12:00 p.m. and 5:00 p.m. scheduled doses.</p> <p>Record review of Resident #24's May 2025 MAR revealed the resident's Sevelamer Carbonate 800 mg tablets (2) were not administered for two of the three opportunities on the following dates:</p> <p>05/02/2025 07:30 a.m. and 12:30 p.m.</p> <p>05/05/2025 07:30 a.m. and 12:30 p.m.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>( 4 missed doses).</p> <p>The Sevelamer Carbonate 800 mg tablets (2) were not administered for three of the three opportunities on the following dates:</p> <p>05/01/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>05/03/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>05/04/2025 07:00 a.m., 12:00 p.m., and 5:00 p.m.</p> <p>05/06/2025</p> <p>(9 missed doses).</p> <p>Record review of Resident #24's May 2025 MAR revealed the resident's Sevelamer Carbonate 800 mg tablets (2) were not administered for one of one opportunity on the following date:</p> <p>05/07/2025 07:30 a.m.</p> <p>(1 missed dose)</p> <p>In an interview on 05/07/25 at 1:23 p.m., RN H said the medication was not available this morning at 7:30 a. m. He said he called the pharmacy and was told the medication was not covered by insurance. He said the pharmacy suggested he call the dialysis center. He said he called the dialysis center but could not recall whom he spoke with. He said the person at the dialysis center said they sent the prescription to the pharmacy, and that it would take 8 to 10 days for the facility to receive it. He said he informed ADON I. RN H said he had inquired about the medication on 05/03/2025. He said he had also called the pharmacy on that day and was referred to the dialysis center. He said the dialysis center had said they would look into it. RN H did not work from 05/04/2025 until his shift on 05/07/2025. He said there was no follow-up prior to 05/07/2025.</p> <p>In an interview and observation on 05/07/25 at 1:40 p.m., ADON I said if a medication was not available, the nurse was to inform him. He said he would then follow up with the doctor and pharmacy. He would inquire about availability and/or a substitute. He said he was unaware that Resident #24 had not been receiving any of his medications. Observation revealed ADON I pulled up Resident #24's MAR on the computer. He said the medication was placed on hold. He was not able to tell who ordered the medication to be placed on hold.</p> <p>In an interview on 05/07/2025 at 2:47 p.m., the DON said he called the pharmacy and approved a 14-day supply. He said the facility would cover the cost. He said the medication would be delivered today by 5:00 p. m. He said the physician was aware of the medication not being available since the beginning of the issue. He said he called the NP this morning and she placed the medication on hold. He said he did not know if the NP was called about this situation prior to today.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview via telephone on 05/07/2025 at 3:00 p.m., the Clinical Nurse Manager of the dialysis facility said there were two nurses working on this date, and both said they did not receive a call about Resident #24. She said Resident #24 was going to be transferring to a different dialysis treatment center on Friday (05/09/2025). She said without the Sevelamer Carbonate, the resident's phosphorous level would go up. Complications could include itching. If the phosphorous level was high enough to go into the circulatory system it could cause cardiac issues. There was not a current phosphorous level lab available for review. She said the dialysis center would not have placed the medication on hold.</p> <p>An attempt to contact the Physician and/or NP was made on 05/07/25 at 3:35 p.m. A message was left, but no return call was received.</p> <p>In an interview via telephone on 05/27/25 at 11:12 a.m., the Physician said within two or three days after Resident #24's Sevelamer Carbonate was not available (04/20/25), he was aware the medication was not available. He said Sevelamer Carbonate was a phosphate binder (medication used to reduce the absorption of dietary phosphate). He said the medication could be held for two weeks without adverse effects. He said the medication could be stopped completely if the resident was attending dialysis. He said the 41 missed doses of Sevelamer Carbonate was not a risk to Resident #24's health. He said Resident #24's syncopal (fainting) was likely unrelated to missing the Sevelamer Carbonate.</p> <p>Record review of a lab report for Resident #24 draw date 05/05/25 revealed his Phosphate level was 7.3 mg/dl, with reference range of 2.6-4.5 mg/dl. The Phosphate level was not 'critical high' at that time.</p> <p>In an interview on 05/27/25 at 1:50 p.m., the DON said the Sevelamer Carbonate 800 mg for Resident #24 had not been available for administration at the facility since 04/21/25. He said some doses were documented as given, but those were in error.</p> <p>Interview with the DON and record review on 05/27/25 at 2:15 p.m. revealed a 14-day supply of the Sevelamer Carbonate 800 mg for Resident #24 was delivered on each of the following dates:</p> <p>02/04/25, 02/15/25, 03/04/25, 03/15/25, 04/01/25, 05/08/25.</p> <p>The DON said that in April 2025 CMS changed the rule, making it the Dialysis Center responsible for ordering the medication from the Pharmacy, no longer the facility responsibility. Therefore, there was no delivery in the middle part of April 2025. He said the facility contacted the Dialysis Center more than once but the Dialysis Center did not call the Pharmacy (unverifiable).</p> <p>Record review of the facility's policy on Pharmacy Services copyrighted 2023, read in part, .7. The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, goals and quality of life that are consistent with current standards of practice and meet state and federal requirements.</p> <p>Record review of the facility's policy on Unavailable Medications implemented 05/10/24, it read in part, .5. IF a resident misses a scheduled dose of the medication staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 19 residents (Residents #61 and #99) reviewed for infection control practices.</p> <p>-The facility failed to ensure CNA A followed proper infection control, cleaning and hand hygiene for Resident #61 during incontinent care. CNA A double gloved, CNA A failed to use a clean washcloth surface area and perform hand hygiene between glove changes during incontinent care.</p> <p>-LVN G checked Resident #99's blood glucose level with a lancet, then discarded the used lancet into the trash can in the resident's room.</p> <p>These failures could place residents at risk of infection or a decline in health.</p> <p>The findings included:</p> <p>Resident #61</p> <p>Record review of Resident #61's admission face sheet undated revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident #61's diagnoses included: dementia (general term for loss of memory, language, problem-solving that interfere with daily function), protein-calorie malnutrition (a condition caused by a lack of sufficient protein and/or calories in the diet).</p> <p>Record review of Resident #61's admission Minimum Data Set (MDS) assessment dated [DATE] and Quarterly MDS dated [DATE] revealed Resident #61's Brief Interview for Mental Status (BIMS) (a score used to assess cognitive function) was 00 which indicated it was unable to be scored. Resident #61's cognitive skills for daily decision making was not scored. Continued review of the MDS revealed Resident #61 was frequently incontinent of her bowel and bladder.</p> <p>Record review of Resident # 61's care plan revision dated on 12/17/2024 revealed:</p> <p>Focus: Resident #61 had an ADL (basic self-care tasks) self-care performance deficit and required cues (signals or prompts that guide behavior, actions or response), set up or assistance with ADL's related to dementia. Goal: The resident would participate in ADLs to her ability. Interventions: Bathing/ Showering: The resident required assistance with bathing/showering by staff as necessary. Personal Hygiene: The resident required assistance by staff with personal hygiene.</p> <p>Record review of Resident #61's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61's Brief Interview for Mental Status (BIMS) (a score used to assess cognitive function) was 00 which indicated it was unable to be scored which indicated sever cognitive issues. Continued review of the MDS revealed Resident #61 was frequently incontinent of her bowel and bladder.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/27/2025
NAME OF PROVIDER OR SUPPLIER  Sugar Land Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  333 Matlage Way Sugar Land, TX 77478	
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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/07/2025 at 8:29 AM during incontinent care revealed Resident #61 was assisted to bed and positioned on her back. CNA A donned (put on) two pairs of gloves and removed Resident #61's pants. CNA A removed the double gloves. CNA A changed her gloves with outperforming hand hygiene (hand washing or hand sanitizing with alcohol base hand gel). CNA A removed Resident #61's brief. Observation of the inside of brief revealed the area from against the skin had discolored brown stains. CNA A changed her gloves without performing any hand hygiene. CNA A wet a washcloth. CNA A separated Resident #61's labia and wiped three separate wipes without refolding or changing the surface area of the washcloth. CNA A changed her gloves without performing hand hygiene. The resident was rolled to her right side. CNA A cleaned the resident's anal area. CNA A changed her gloves without performing any hand hygiene. CNA A cleaned the resident's buttocks. CNA A placed a clean brief on the resident.</p> <p>In an interview on 05/07/2025 at 1:36 PM CNA A stated she did double glove. CNA A stated double gloving was not supposed to be done. CNA A stated she did it because the gloves were tight and were at risk of being torn. CNA A stated she did not take the time to get new sized gloves. CNA A stated she did not clean or sanitize between the glove changes. CNA A stated she was taught to do hand hygiene between glove changes. CNA A stated she was nervous and not thinking about what she was doing. CNA A stated she thought she did turn the washcloth between wiping. CNA A stated she was trained to turn the washcloth to another clean side. The CNA stated the risk was contamination and infections.</p> <p>In an interview on 05/07/2025 at 3:33 PM IC RN stated double gloving was not recommended due to it not being hygienic (preventing disease). IC RN stated hand hygiene was to be done between glove changes. The IC RN stated the residents were to be wiped three times between the labia when cleaning, but a new wipe was to be used each time. IC RN stated the incontinent care that was performed was not good, it was not aseptic (free from contamination) the risk to the resident was infection.</p> <p>In an interview on 05/07/2025 at 4:09 PM the DON stated double gloving was not acceptable due to infection control issues and hand hygiene was supposed to be done between every glove change. DON stated different wipes were to be used with each wipe not reusing the same washcloth. The DON stated the risk to the resident was an infection.</p> <p>In an interview and record review on 05/07/2025 at 4:30 PM the Administrator stated her expectation was for proper infection control technique was done with incontinent care. The Administrator stated she reviewed the record and CNA A did her peri care check off on 03/03/2025. The Administrator stated she did not know what went wrong at this time. The Administrator stated hand hygiene was to be done with each glove change. The Administrator stated she says when cleaning it was one wipe one swipe. The Administrator stated disposable wipes were available to use unless the resident preferred a washcloth, but it was to be changed with each wipe. The risk to the resident was an infection. To prevent this, she would in-service on proper incontinent care.</p> <p>Record review of the facility policy titled Perineal Care Implemented dated 05/10/2024 read in part . . .11. Females: c. Separate the resident's labia with one hand and cleanse the perineum with the other hand by wiping in the directions from front to back (from pubic area towards anus). d. Repeat on opposite side using separate section of washcloth or new disposable wipe .</p> <p>Resident #99</p> <p>Resident #99</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Sugar Land Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  333 Matlage Way Sugar Land, TX 77478	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #99's admission Record (copied 05/08/2025) revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension (high blood pressure), and fracture of the right femur (hip).</p> <p>Record review of Resident #99's Physician's Order dated 05/05/2025 revealed he was to receive Metformin HCl (antidiabetic) 500 mg every 12 hours.</p> <p>Record review of Resident #99's Care Plan dated 05/05/2025 revealed the resident had an order for a hypoglycemic (antidiabetic) medication and required monitoring of blood glucose levels.</p> <p>Observation and interview on 05/07/2025 at 7:32 a.m. revealed LVN G was at her medication cart in the doorway of Resident #99's room. LVN G dispensed three tablets to be administered to Resident #99. One of the medications dispensed was a 500 mg tablet of Metformin HCl. LVN G said she was required to check Resident #99's blood glucose level prior to administering the Metformin.</p> <p>Continued observation revealed LVN G pricked Resident #99's left index finger with a lancet. LVN G used a glucometer to check the resident's blood glucose level (result was 104 mg/dl). LVN G then discarded the used lancet into the resident's trash can in the room. LVN G administered the three tablets to Resident #99. LVN G left the room and returned to her medication cart. She said she should have placed the lancet into the sharps container, and that discarding it into the trash can could be a risk for infection.</p> <p>In an interview on 05/07/2025 at 8:35 a.m. the DON said used lancets should be discarded into the sharps containers. He said it could be a big danger and was definitely an infection control concern.</p> <p>The OSHA Fact Sheet 'Protecting Yourself When Handling Contaminated Sharps (presented by the facility when asked for Policy) read, in part, .A needlestick or a cut from a contaminated sharp can result in a worker being infected with human immunodeficiency virus (HIV), hepatitis B (HBV), hepatitis C (HCV), and other bloodborne pathogens. The document also read, in part, .Employers must ensure that contaminated sharps are disposed of in sharps disposal containers immediately or as feasible after use.</p>		