STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675540	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health Care Center	1206 N Travis St Liberty, TX 77575

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident, that included measurable objectives and timeframes to meet a resident's needs identified in the comprehensive assessment for 1 of 20 residents reviewed for following physician orders. (Resident #27) The facility did not apply Resident #27's hand splint as ordered by the physician This failure could place the residents at risk of a decline in their range of motion. Findings included: Record review of physician orders dated June 2024 indicated Resident #27, admitted [DATE], was an [AGE] year-old female with diagnoses of muscle wasting and atrophy and cerebral infarction (a condition that occurs when blood flow to the brain is disrupted causing the brain tissue to die). The orders indicated the resident was to have a resting hand splint to the right upper extremity to prevent contracture. The hand splint was to be removed every night. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #27 had a BIMs of 4 (Severe cognitive impairment), had an impairment in ROM to one side of the upper extremities and was dependent for personal hygiene and toileting. Record review of a care plan revised 02/16/24 indicated Resident #27 had limited physical mobility or was at risk for a decline in mobility related to a limited range of motion to the right arm/hand. Record review of an ADL task sheet dated June 2024 for Resident #27 indicated the CNAs were to apply a resting hand splint to the resident's right upper extremity each morning and remove each night to prevent contractures. During observations, Resident #27 had her right hand clenched tightly with the fingers and thumb positioned inward towards the palm of the hand but opened it when asked. The resident did not have a splint to the right hand: *on 06/23/24 at 10:48 a.m., (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*on 06/24/24 at 8:33 a.m., *on 06/25/24 at 2:42 p.m., and *on 06/25/24 at 9:44 a.m. During observation and interview on 06/25/24 at 9:44 a.m., Resident #27 was sitting in the common area with her right hand closed tightly. The surveyor asked the resident to open her hand and the resident was able to straighten all fingers out. The DON said the resident was supposed to have a splint in her hand as ordered. She said the possible negative outcome could be the resident's hand could become contracted. She said her expectation was for the resident to have the splint in her hand as ordered. During observation and interview on 06/25/24 at 9:53 a.m., upon entering Resident #27's room, the DON retrieved the resident's splint from the top of the chest of drawers and said here it is. The DON said the splint was not applied as ordered. She said it was the CNA's responsibility to make sure the splint was applied. During an interview on 06/25/24 at 10:50 a.m., CNA E said she worked on Hall 600, where Resident #27 resided. She said she was not aware she was supposed to apply the splint to Resident #27's right hand and no one had told her she was supposed to until then. She said she did look at the aide assignment sheet for the resident and did see the splint was to be applied to the right hand but she did not ever see a hand splint so she did not apply it. She said the possible negative outcome of not applying the splint would be the resident's hand could get to the point of not opening and she would not be able to use it. Review of the Prevention of the decline in Range of Motion policy dated 2023 indicated The facility in collaboration with the medical director, director of nurses and as appropriate, physical/ occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventive care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review, the facility failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 1 of 1 resident (Resident #272) reviewed for enteral feeding. The facility failed to ensure LVN A verified placement of Resident #272's G-tube by checking for tube placement before enteral administration of water and medications. The facility failed to ensure LVN A administered the flushes and medications using gravity. These failures could place residents receiving enteral nutrition and medications at increased risk of not receiving proper nutrition, infection, aspiration, and possible injury. Findings included: Record review of Resident #272's physician orders dated June 2024 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included dysphagia (difficulty or discomfort swallowing). Orders indicated he was NPO (nothing by mouth), was to receive all feedings and medications via G-tube (a tube inserted through the stomach that brings nutrition directly to the stomach) and tube placement was to be verified before each use by change in the incremental marking on tube, documented tube length, gastric residual volume, or by pH of aspirate. Record review of a care plan dated 06/21/24 indicated Resident #272 had a feeding tube. Interventions included to administer enteral feeding, medications, and water flushes as ordered. During an observation and interview during medication administration on 06/24/24 at 09:30 a.m., LVN A did not check placement of Resident #272's G-tube prior to administration of water flushes and medications through the G-tube. LVN A flushed the tube with water, she drew up the medications individually with the syringe, administered the medications using the plunger in the syringe, drew up the water between medications using the syringe, flushed the water using the plunger in the syringe, then did the final flush of the tube with water. LVN A said she would not have done anything different in the procedure. During an interview on 06/25/24 at 10:35 a.m. the DON indicated staff should follow the policy for gastrostomy tube placement check and flushes/medications should be administered via gravity. She indicated the flushes and medications should be done via gravity and not pushed through the syringe with the plunger. She indicated injury could occur from pushing fluids or medications through the gastrostomy tube. Record review of the Confirming Placement of Feeding Tubes policy and procedure revised November 2018 indicated Purpose: The purpose of this procedure is to ensure proper placement of an existing feeding tube prior to administering enteral feedings or medication.Steps in the Procedure: .To Confirm Placement of an Existing Feeding Tube at the Bedside: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Use one of the following methods to test whether the tube is properly positioned: a. Observe for symptoms of elevated gastric residual volume (GRV - Please see GVR Policy), or: (1) A sharp increase in residual volume may indicate that a small bowel tube has moved into the stomach; (2) Little to no residual volume may suggest that the tube has migrated from the stomach to the esophagus. b. Observe and check the pH of aspirate: (1) Fasting stomach contents will have a clear and colorless or grassy green and brown appearance. (2) Fluids from the pleural space may have a pale yellow, serous appearance. (3) Post-pyloric/small bowel contents can be bile-stained, light to dark yellow or greenish-brown. (4) Fasting stomach acid will have a pH of 5 or less. (5) Fluid from the pleural space will have a pH of 7 or higher. (6) A pH of 5 or less suggests that the tube is placed in the stomach. However, a pH of 6 or greater is not definitive of placement outside the stomach. 2. If the above suggests improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician. 3. When correct tube placement has been verified, flush tubing with at least 30 mL water (or prescribed amount) Record review of the Administering Medications through an Enteral Tube policy and procedure revised November 2018 indicated Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube Steps in the Procedure: 6. Verify placement of feeding tube: a. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician. 10. Administer each medication separately. 11. Reattach syringe (without plunger) to the end of the tubing. 12. Administer medication by gravity flow: a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. b. Open the clamp and deliver medication slowly. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Begin flush before the tubing drains completely. 13. If administering more than one medication, flush with 15 mL warm purified water (or prescribed amount) between medications. 14. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of warm purified water (or prescribed amount). 15. Quickly clamp the tubing when the flush is complete. Remove syringe

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 30664 Based on interview and record review, the facility failed to ensure pharmacy procedures to ensure an accurate accounting of all controlled drugs and the licensed pharmacist failed to ensure the drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 2 of 4 medication carts reviewed for narcotic counts. (300 Hall Nurse Cart and 200/500 Halls Medication Aide Cart) The facility did not ensure staff were conducting accounting of Controlled Drugs at shift change on the 300 Hall Nurse Cart and 200/500 Halls Medication Aide Cart. The Pharmacy Consultant did not ensure the Controlled Drugs - Count Record forms had signatures of the staff indicating the Controlled Drugs were reconciled. These failures could place residents at risk for misappropriation and drug diversion. Findings included: Record review of the June 2024 Controlled Drugs - Count Record form on the 300 Hall Nurse Cart indicated: *on the day shift the nurse going off shift did not sign the form on 1st, 5th, 6th, 10th, 12th, 13th, 19th, 20th, and 21st; *on the night shift the nurse going off shift did not sign the form on the 14 th ; *on the night shift the nurse coming on shift did not sign on 4th, 5th, 8th, 11th, 12th, 13th, 18th, and 19th; and *there were no signatures on the day shift on the 14th and 20th; and *there were no signatures on the night shift on the 20th. Record review of the June 2024 Controlled Drugs - Count Record form on the 200/500 right side Halls Medication Aide Cart indicated: *on the day shift the Medication Aide coming on shift did not sign on 4th, 5th, 10th, 18th, 19th, 21st, 22nd, 23rd, and 24th; and *on the night shift the Medication Aide going off shift did not sign on 4th, 5th, 8th, 10th, 18th, 19th, 21st, 22nd, 23rd, 24th, and 25th. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Consultant Pharmacist Activity Report dated 06/18/24 indicated Special Notes/Activities: The medication room and carts were reviewed There was no indication on the report of missing signatures on the Controlled Drugs - Count Record forms on the medication aide or the nurse carts. During an interview on 06/25/24 at 12:40 p.m., MA C indicated if the narcotics were not counted then the medications could be missing and because the sheet was not signed as to who had the cart they would not know who would be accountable for missing medications. During an interview on 06/25/24 at 01:09 p.m., MA D indicated she was not trained on the cart count sheet. During an interview on 06/25/24 at 12:39 p.m., the DON indicated she expected staff to count the narcotics on the medication carts. She indicated if the counts were not done then there could be a drug diversion and she would not know who would be accountable for missing medications. During an interview on 06/25/24 at 12:39 p.m., the DON indicated the no signature could indicated the narcotic counts were not done. Pharmacy Consultant was at the facility a few days ago and reviewed the medication aides and nurse carts. She indicated there was no report of any issues with the count sheets. During a phone interview on 06/25/24 at 01:50 p.m., the Pharmacy Consultant indicated she was supposed to check the signature count to ensure the staff are counting medications between shifts before they hand off the keys. She said she did not notice the missing signatures on the cart count sheets. She said the possible negative outcome could be a drug diversion. Record review of a Controlled Substances policy revised April 2019 indicated Policy Statement: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Policy Interpretation and Implementation: .4. Access to controlled medications remains locked at all times and access is recorded. .8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. .12. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together Record review of a Pharmacy Services - Role of the Consultant Pharmacist policy revised April 2019 indicated Policy Interpretation and Implementation: 5. The consultant pharmacist will provide specific activities related to medication regimen review including: d. review of medication storage areas at least monthly, and medication carts at least quarterly, for proper storage and labeling of medications, cleanliness, and expired medications;

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 30664 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access, for 2 of 2 medications reviewed for security. The facility did not ensure clonidine (medication to treat elevated blood pressure) and a Fentanyl patch (narcotic opioid pain medication) medication was stored securely when it was left unattended at the nursing station. This failure could place residents at risk for harm by misappropriation of property and drug diversion. Findings included: During an observation on 06/23/24 at 12:28 p.m. of the nurse station, a card of clonidine (medication to treat elevated blood pressure) and a Fentanyl (narcotic opioid pain medication) patch were left on the desk unattended by a nurse or medication aide and accessible to staff, residents, and visitors. During an interview on 06/23/24 at 12:30 p.m., the Administrator was shown the card of clonidine and Fentanyl patch were on the desk of the nurse station unattended by a nurse or medication aide. He said medications were not to be left at the nurse station unattended by the staff as they could be removed by anyone walking by. During an interview on 06/23/24 at 12:32 p.m., LVN B indicated she had the card of clonidine to put on the cart and was reordering the Fentanyl patch when she got up to leave the nurse station. She said she should not have left the medications at the desk. During an interview on 06/25/24 at 02:09 p.m. during the exit, the DON indicated she was aware of the medications being left at the nurse station and medications were not to be left to where anyone could get them. Record review of a Controlled Substance policy revised April 2019 indicated Policy Statement: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Policy Interpretation and Implementation: .3. Controlled substances are stored in the medication room in a locked container, separate from containers for any non-controlled medications. 4. Access to controlled medications remains locked at all times and access is recorded