STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675649	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Health Rehab	11127 Circle Dr Austin, TX 78736

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to properly store and label biologicals for one (Resident #1) of five residents reviewed for improper medication storage, in that: The facility failed to remove Resident #1's narcotics (Hydrocodone) from the medication cart when it was discontinued July of 2023 which resulted in a medication diversion on 03/09/24. This noncompliance was identified as PNC. The deficient practice began on 03/09/24 and ended on 03/12/24. The facility had corrected the noncompliance before the survey began. This failure could place residents whose narcotics have been discontinued at risk of receiving discharged discontinued medication, medication errors, and drug diversion. Findings included: 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 unspecified dementia, repeated falls, scoliosis (curvature of the spine or back bone), delusional disorders, and major depressive disorder. Review of Resident #1's quarterly MDS assessment, dated 01/01/24, reflected a BIMS of 9, indicating a moderate cognitive impairment. Section J (Health Conditions) reflected she was not receiving a scheduled pain medication regimen. Review of Resident #1's quarterly care plan, dated 01/01/24, reflected she was at risk for pain related to multiple issues with an intervention of administering pain medications as ordered by the physician. Review of Resident #1's physician order, dated 06/01/23, reflected the following: Hydrocodone-Acetaminophen Oral Tablet 5.325 MG - give 1 tablet by mouth every 6 hours as needed for pain. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's discontinued orders , on 04/04/24, reflected her order for Hydrocodone was discontinued on 07/05/23. Review of Resident #1's Controlled Substance Administration Record, on 04/04/24, reflected she was administered the discontinued Hydrocodone on 09/27/23 and 11/30/23. Review of the facility's Investigation Summary, dated 03/09/24, reflected the following: Summary: On the morning of 3/9/24 during the narcotic count of the 100 Hall Nurse Cart between the off-going 100 Hall Charge Nurse and on-coming nurse, they observed a blister pack of hydrocodone/APAP TAB 5-325 MG altered. Two of the doses, 27 and 28, appeared to opened at some point with two different medications inserted and then taped closed on the backside of the pack. The medication is a PRN ordered for [Resident #1]. Per the narcotic sheet, the last dose was administered in November 20, 2023. The other remaining medications in the blister pack were secure and untampered. The nurses reported their observance to the DON. [Resident #1] was assessed for pain and none was noted. As it was ordered as needed she did not miss a scheduled dose and the remaining supply was more than sufficient to meet any pain management need. Per review of records and assessment, the resident did not have any unmet pain management needs nor experience a negative impact due to the incident. Facility administration reported the incident to the (police department), [case number] . The responding officer and Administrator verified the two substituted medications were (medications). Facility leadership notified the resident representative, Medical Director, and HHSC via self-report. Facility Administration initiated an investigation by auditing all narcotics against the narcotic sheets for each of the medication carts in use. No other blister packs were altered and all medications were accounted for. Per audit by the DON, Consulting Pharmacist, and Regional Clinical Nurse, it was identified that the order had been discharged in July 2023, however the medication remained on the cart in error. As it was administered after the order had been discharged , it constitutes a med error and has since been addressed accordingly. Facility leadership interviewed all current staff members who had access to the nurses cart. All staff interviewed denied removing the medications nor were aware of when or how the blister pack was manipulated. Nursing staff were in-serviced on medication administration protocol, policy to waste medication if erroneously/accidentally popped from blister pack, and prompt removal of discharged medications from the medication carts. Clinical leadership established a performance improvement plan to monitor for compliance. Immediate response: Assessed resident for pain and/or adverse effects; none noted Secured blister pack Notified Resident Representative Notified Medical Director Notified (police department) Case Notified HHSC via self-report Initiated investigation; No observations of other tampered medication (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Actions: 3/9/24 - Admin checked narcotics against narc sheets on all carts and verified integrity of packaging. No other issues noted. 3/12/24 - DON, Pharmacy Consultant, Regional Nurse conducted additional audits; Checked active orders against narcotics on carts and against narcotic sheets. Identified [Resident #1]'s hydrocodone was DC'd and med should have been removed from cart. Checked integrity of medication packaging. Observed other taped meds on blister packs and confirmed medication was actual med. Inserviced staff to waste meds instead of attempting to save them and resecure in packaging. Conclusion: Confirmed. The Hydrocodone blister pack was clearly tampered with and other medications were placed in the spaces for the two missing doses. As the order for the medication was discharged and the medication should have been removed, there was no misappropriation of resident property. There is no conclusive evidence to identify a person responsible for tampering with the blister pack. As such, the investigation provided opportunity to review current practices and provide education to nursing staff regarding medication administration protocols and overall medication management policies. Nursing leadership created a PIP to audit and track compliance. Review of the facility's PIP, dated 03/10/24, reflected the following: Observation: A narcotic blister pack was not removed from the medication cart timely after the medication was discharged . Goal/Objective: Timely removal of DC'd narcotics from medication carts Actions: Educate Nurses and CMAs of policy and procedure to remove DC narcotics from cart once DC'd from patient MAR. Responsible Party: DON/ADON Date Completed: 3/11/24 Goal/Objective: Monthly, random audits of active narcotic orders against narcotics on all medication carts. Responsible Party: DON or Designee Date Completed: March, 2024; April 2024; May 2024 Comments: DON/Designee to updated on findings each month and report in QAPI x3 months. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's self-report to HHSC, dated 03/10/24, reflected the medication discrepancy was reported in a timely manner. Review of an in-service entitled Narcotics/Count/Discrepancies/Drug Diversion, dated 03/11/24 and conducted by the DON, reflected nurses and medication aides from all shifts were educated on the following: - Ensure you always have a correct count of narcotic before you take keys from ongoing nurse or MA. - Pay attention to the back of each blister card. - If a medication has been discontinued, pull it out of the cart and give to DON (only when you see her in person). - If a resident is not using a PRN or not needing it, notify NP if you can discontinue. - All discontinued orders: you must pull the blister pack and give to DON in person (with a co-signature) Review of an in-service entitled Blister Packs, dated 03/12/24 and conducted by the DON, reflected nurses and medication aides from all shifts were educated on the following: - If a blister pack gets torn or breaks, you must waste the pill inside. - No tape allowed if it is torn, you must waste it always have a witness with you. - You must be looking at (EMR) for your order first. During an observation and interview on 04/04/24 at 11:02 AM revealed the DON chose three random narcotic blister packs from a medication cart for three different residents. The medications were reviewed against the resident's orders and matched accordingly. A count of the blister packs was checked versus the narcotic count sheet. Blister packs were observed to not have any signs of tampering. She stated it was the nurse's responsibly to ensure narcotics were taken off the medication carts if there was an order for discontinuation. During an observation and interview on 04/04/24 at 11:18 AM revealed LVN A choosing three random narcotic blister packs from a medication cart for three different residents from a different medication cart. The medications were reviewed against the resident's orders and matched accordingly. A count of the blister packs was checked versus the narcotic count sheet. Blister packs were observed to not have any signs of tampering. She stated before administering a narcotic the most important thing was to ensure the resident had an order and the dosage matched. She stated when doing a narcotic count at the beginning and end of her shift, she ensured the numbers matched and the blister packs were intact. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/04/24 at 12:26 PM, LVN B stated when he was conducting a narcotic count at the beginning and ending of each shift, he was ensuring the narcotic log matches the blister pack, looking to see if anything looked suspicious, looked at back of the blister pack to ensure it had not been tampered with, and looking to ensure no random pills had popped out in the cart. He stated before administering any medications to a resident, he made sure there was an order for it in the resident's EMR. He stated if a narcotic was to get discontinued by the NP, he would take the blister pack and count sheet from the cart and take them to the DON and they both would do a count a sign off. During an interview on 04/04/24 at 2:10 PM, LVN C stated when she was doing a narcotic count, she was making sure the counts matched, would turn the blister pack around to ensure it had not been tampered with. She stated it if looked off she would notify the DON immediately. She stated before she administered medications, she ensured it matches with the resident's order. She stated if there was not an order in the chart, she would call the doctor. She stated if a narcotic got discontinued, she would pull the medication and the count sheet and take them to the DON to count and sign off. Review of the facility's Controlled Substances Policy, Revised November of 2022, reflected the following: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. . 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records.