STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER: Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 615 Lawrence St Tomball, TX 77375	

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on observation, 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 for 1 of 5 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1 received the correct dose of Vitamin D3 (a dietary supplement to help maintain bone health and for vitamin deficiency) as written by the physician. LVN A failed to confirm the correct dose of Vitamin D3 prior to administration. This failure could place residents at risk of not receiving the intended therapeutic benefits of the medications. Findings included: Record review of Resident 1#'s face sheet dated 08/21/2024, reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Wernicke's Encephalopathy (brain and memory disorder), cocaine dependence, schizoaffective disorder, anxiety disorder, vitamin deficiency, hypertension and vitamin D deficiency. Record review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 3 out of 15, indicating severe cognitive impairment. He required supervision or set up for ADL's. He was always continent of bowel and bladder. Record review of Resident #1's undated care plan reflected a nutritional risk related to advanced age and interventions to include administer medications as ordered. Further review reflected the diagnosis of vitamin D deficiency was not addressed. Record review of Resident #1's physician's orders as of 08/21/2024 reflected an order for Vitamin D3 125mcg 1 capsule daily by mouth related to vitamin deficiency. Record review of Resident #1's MAR for August 2024 reflected that LVN A documented administering Vitamin D3 125 mcg capsule on 8/21/2024. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview during medication pass on 08/21/2024 at 8:15AM in the memory care unit, revealed LVN A prepared medications for Resident #1. LVN A prepared the following medications: Gabapentin 300mg one capsule, Bupropion HCL SR 150mg one tablet, Prezcobix 800mg/150mg one tablet, Loratadine 10mg one tablet, Folic acid 1mg tablet, multi-vitamin one tablet, thiamine vitamin B-1 100mg one tablet, Emtricitabine 200mg one tablet and Vitamin D3 25mcg 2 tablets. LVN A administered the medications to Resident #1. In an interview and observation on 08/21/2024 at 11:35AM, LVN A stated she started working at the facility around 06/26/2024 and was a full-time employee. Observation of the medication cart in the memory care unit revealed a bottle of Vitamin D3 25mcg. Further observation of the medication cart revealed there was no Vitamin D3 125mcg. LVN A stated she gave Resident #1 two tablets of Vitamin D3 25cmg and stated that the order was for 2 tablets. LVN A stated she missed reading the correct dose on the bottle. LVN A stated Resident #1 was receiving Vitamin D3 for a vitamin deficiency and the risk of not getting the correct dose was Vitamin D deficiency. LVN A stated when she prepared medication for administration to residents, she checked for the right medication, right dose, right amount and right patient/resident. LVN A stated it was important to give the correct medications as written by the physician so the resident would receive the adequate amount. LVN A stated she believed she did the medication competency checklist during orientation and that it was conducted by the DON and ADON. LVN A stated going forward she would be able to write a self-report in the eHR system for medication errors. LVN A stated she would notify the family and the MD of the med error. In an interview on 08/21/2024 at 2:00PM, the DON stated she expected the nursing staff to check the physician orders and make sure orders were still valid, current and nothing had changed. She stated she expected the nurses to check for the right resident, right dose, right medications, right time, no allergies, no contraindications and to check consents if needed prior to administering medications. The DON stated the nurse called the NP when she missed giving the correct dose and that the order could have been put in the system incorrectly, that it was probably supposed to read Vitamin D3 25mcg and not 125mcg as the facility did not have bottles of the 125mcg. The DON stated it was the responsibility of the person transcribing the order to have made sure what was entered was correct and of course when giving the medication, the nurse should have confirmed the dose. The DON stated Resident #1 was receiving Vitamin D3 as a supplement as he had several different diagnoses that would cause low Vitamin D levels also, he was not a big eater and needed to get more nutrients. The DON stated the risk of not receiving the correct dose of Vitamin D3 could be side effects of an overt dose especially if his labs are being regulated or there could have been a contraindication. Record review of the facility policy for Medication Administration, copyright 2024 reflected in part: . Medications are administered by licensed nurses .as ordered by the physician .Policy Explanation and Compliance Guidelines: .10. Ensure that the six rights of medication administration are followed: a. Right resident, b. Right drug, c. Right dose, c. Right route, e. Right time, f. Right documentation. 11. Review MAR to identify medication to be administered. 12. Compare medication source .with MAR to verify resident name, medication name, form, dose, route and time .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on observation, interviews and record review the facility failed to ensure all drugs and biologicals were stored securely for one (Nurse Cart for B Hall/D Hall) of three medication carts reviewed for storage of medications. The Nurse Cart for B Hall/D Hall contained medications without resident identifiers. The Nurse Cart for B Hall/D Hall contained a narcotic medication blister pill card with a punctured protective seal. The failures could place all residents at risk of not receiving the therapeutic benefit of medications, infection, adverse reactions to medications and drug diversion. Findings included: Record review of Resident #2's face sheet dated 08/20/2024 reflected a [AGE] year-old female, admitted to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included dementia, bipolar disorder, diabetes with diabetic neuropathy (nerve damage that can occur with diabetes), depression and chronic pain. Record review of Resident #2's physician's orders as of 08/20/2024 reflected an order for Cannabidiol Oral Solution, 15 drops at bedtime for anxiety/sleep, date started 04/05/2024. Observation on 08/21/2024 at 6:30 AM, revealed in the top drawer of the Nurse medication cart for B Hall/D Hall contained a bottle of Refresh Tears without a resident identifier, and a bottle of CBD (Cannabidiol) oil (a hemp supplement) without a resident identifier. The CBD oil bottle was in the compartment with eye drops. Further review of the top drawer revealed one insulin pen, Lispro (a fast-acting insulin that lowers blood sugar in people with diabetes) without a resident identifier and a second insulin pen, Aspart (a fast-acting insulin that lowers blood sugar in people with diabetes). Both insulin pens contained fluid. Interview on 08/21/2024 at 6:30AM, LVN B stated she was the charge nurse and worked the 7:00PM to 7:00AM shift. LVN B stated she did not use or open the cart on her shift and did not know why the insulin pens, refresh eye drops, and CBD oil were not labeled. LVN B stated the only resident she was aware who used the CBD oil was Resident #2. LVN B stated the Refresh Tears eye drops and the CBD oil should have been in the original boxes with pharmacy labels and resident names. LVN B stated the risk of medications without resident identifiers was that a resident could be given the incorrect medication and cross contamination from being used on another resident. LVN B stated it was the facility's policy to have resident identifiers on all medications. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 08/21/2024 at 9:00AM, the Nurse medication cart for B Hall/D Hall, revealed a narcotic lock box that contained a Hydrocodone-APAP 10-325mg blister pill card with pin holes on the back of one of the pill compartments (Compartment #5). RN C stated that yes there were 2 pin holes on the back of the blister pill card and that a contaminant could get into where the tablet was. RN C further stated that when ingested a resident may get sick and if the holes got larger the pill could fall out, someone could pick it up, eat it and get sick. RN C stated if there was a tear on the protective seal, she would not tape it but knew instead to waste the pill and that she did not know what to do if there were pin holes. RN C then stated that she would waste it with another nurse to be safe. In an interview on 08/21/2024 at 2:00 PM, the DON stated insulin pens should always have the resident name on the pen and on the bag including the date opened along with pharmacy labels. The DON stated the nurse in charge of the medication cart would be responsible for ensuring all medications were labeled and that ultimately all the nurses were responsible to ensure proper labeling of medications. The DON stated possibly the bags for the insulin pens were lost and that the nurses would not intentionally remove the labels. The DON stated that it was unfortunate that it happened and would expect the nurses to discard the pens when found. The DON stated the nurses just did not write the resident name on the bottle of Refresh Tears and the CBD oil did not come from a pharmacy, the original box may have been lost. The DON stated it would be ideal to have the box for the CBD oil or have the resident's name written on the bottle. The DON stated it would be important because not everyone would be familiar with Resident #2, especially agency staff and that it was facility policy to have all medications with resident identifiers. The DON stated it was the nurses assigned to the carts responsibility to maintain accuracy of the medications in the carts. The DON stated it ultimately fell on the DON and ADON to make sure the nurses were doing their duties. The DON stated she expected the nurses to check the carts at the beginning and end of shift during counting. The DON stated she expected the nurse coming on shift to also ensure everything was in order with the medication carts. The DON stated she expected the nurse leaving and the nurse coming on shift to make sure the cart had been checked for any errors. The DON stated she taught the nurses to check the protective seals were intact on the blister pill cards and ensure it did not look tampered with. The DON continued by stating that if the seal were broken, the pill could fall out, get lost, could be tampered with and may not be the correct pill as a result a resident could be harmed and possible harm to nurse licenses as well. Record review of the facility policy for Medication Storage, dated 2023 reflected in part: .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms .and sufficient to ensure proper sanitation .security .1a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts .2b. Scheduled II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area . Record review of the facility policy for Injection Safety - Drug Diversion, dated 2023 reflected in part: . Definitions: Drug Diversion refers to the theft or other deviations that removes a prescription drug from its intended path form the manufacturer to the patient .2. Staff with access to medications are trained on their responsibilities for safe storage and administration of medications .3. Staff with access to controlled medications are trained on the facility's policy for the administration and accountability of controlled substances .5. Ongoing supervision and auditing are conducted in accordance with facility policy to verify that staff are following policies as written .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35897 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. 1. The facility failed to ensure foods were dated as opened/preparation discarded after 96 Hours (4 days) per facility policy 2. The facility failed to keep food off the floor. These failures could place residents at risk of food borne illness and disease. Findings Include: Observation of the facility kitchen on 08/20/24 at 8:15 AM revealed the following. 1. 5 chicken sandwiches in the walk in cooler had use by date 8/19/24. 2. A Plastic container of deli sliced ham in the walk-in cooler had no label/ no date 3. A plastic container - of shredded lettuce dated 8/12/24 and no use by date. 4. A quart of potato salad dated 8/9/24 , and a use by date of 8/15/24 5. 1case of produce - in the walk- in cooler was stored on the floor 6. 1case of chicken in- the walk- in freezer was stored on the floor 7. 1case of French fries- in walk- in freezer was stored on the floor 8. 2cases of breakfast sausage- in walk- in freezer were stored on the floor In an interview with the Dietary Food Service Manager on 08/20/24 at 8:30 AM, he stated the leftover food stored in the refrigerator should have been used or discarded prior to use by date. He stated the cases of food should be off the floor due to cross contamination. He stated he or designee , shall be responsible for checking the refrigerator daily for food items that are expiring, and shall be discarded prior to expiration date. Record review of facility's policies and procedures for Food Safety dated 2004 reflected in part .potentially hazardous leftover foods are properly covered, labeled, dated, and refrigerated immediately. They are discarded after 96 hours unless otherwise indicated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policies and procedures for Food Safety Requirements dated 2004 reflected in part b. foods/beverages be stored in a clean, dry area off the floor to prevent cross contamination.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 35897 Based on observation, interview, and record review the facility failed to dispose of garbage and refuse properly for 1 of 2 dumpster reviewed for food and nutrition services. -The facility failed to ensure the dumpster door was closed at all times when no one was dumping garbage . This failure could place residents at risk of infection from improperly disposed garbage. Findings include: Observation on 08-20-24 at 8:45 am, revealed the facility's dumpster area, which was in the lot behind the dietary department had a commercial -size dumpster 3/4 full of garbage and dumpster door was open. In an interview on 08-20-24 at 8:45 am, with the Food Service Manager, he stated the dumpster door when not in use should have doors closed to keep vermin, pests, and insects out of the dumpster and from entering the facility. He stated housekeeping, and nursing also discarded their waste garbage in the dumpster. It was the responsibility of staff from dietary, nursing and housekeeping for ensuring the dumpster doors are kept closed when not in use. Record review of facility's Policies and Procedures on disposal of garbage and refuse dated 2024 read in part 7. Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors or covers. Containers and dumpster shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized.