STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tomball Rehab & Nursing	815 N Peach 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** 47277 Based on observation, interviews and record reviews, 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 (R #1) reviewed for medication administration The facility failed to ensure Resident #1 was administered the 6:30am Lantus Solution-Insulin injection for a metabolic disorder that affects glucose metabolism (a medication used to treat pain) by LVN A. This failure could place residents at risk for a delay in medication administration and medication error and could result in a decline in health. Findings included: Review of R#1's face sheet revealed he was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident was diagnosed with type 2 Diabetes Melltus without complication (prevents the body from producing insulin), Hypertension (high blood pressure), chronic kidney disease (kidneys are damage and can't filter blood), peripheral vascular disease (slow progressive disorder or the blood vessels). Review of R#1 orders revealed, (insulin Glargine)-Inject 15 units subcutaneously in the morning; (orders start 6/8/23 at 6:30am); Accu Checks blood levels two times a day for DM (diabetes Mellitus (orders Start 1/28/23 at 8:00am); Vital signs twice daily and record in PCC (electronic health record) every day and evening shift (order Start 11/14/2022); Adverse drug event monitoring by licensed nurse, every shift, to observed resident for side effects from taking an Anticoagulant, antidiabetic and cardiac medication, which could cause excessive bleeding, blood pressure issues; Check catheter (a tube inserted into bladder, allowing urine to drain freely) for infection and trauma (order Start 8/16/2019); Elevate head of bed to >30 degrees at all times every shift (order Start 1/26/2016). Review of R#1's annual MDS assessment, dated 5/19/2024 revealed BIMS of 03, which indicates severe cognitive impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R #1's care plan dated 10/31/2018 was at risk for pain r/t stage 4 pressure ulcer and administered meds as ordered by MD (medical doctor) (initiated 3/2/2018 and revision on 4/11/2023), Catheter care every shift cleanse site daily and apply dry dressing daily (date initiated 7/24/2015), resident is currently taking antihypertensive medication which should be administered as ordered. Monitor for side effects such as orthostatic hypotension, headache, vertigo, chest pain, and decreased heart rate (Bradycardia); give medications for improved blood flow or anticoagulants as ordered Plavix 75mg QD (initiated 7/24/2015 and revision 6/3/2021); resident is at risk for unstable blood sugars related to type II diabetes (Insulin-date initiated 7/24/2015 revision 6/19/2023)-Administer diabetes medications as ordered by the physician and monitor for adverse reactions and report as detected. Review of R#1's electronic nursing notes revealed no nursing documentation at all in R#1's notes between 6/6/2024 at 2:06pm and 6/13/2024 5:05pm. MAR revealed no vital signs or monitoring resident for adverse medication effects on 6/8/2024 during the 6:00am-2:00pm. In an interview with LVN A on 6/20/24 at 1:09pm, she was working the 6am-2pm shift on 6/8/2024. Also during the interview with LVN A, she stated she was assigned and worked the 500 hall. LVN A stated she administered medication and documented in the EMAR/ETAR during her shift. LVN A stated she has no idea and does not know why there was no documentation in the resident's orders or in PCC during her shift. LVN A stated there must have been an issue in getting service on the 500 hall area. LVN A stated it was important to document along with following the physician orders regarding residents' conditions. She further stated it was equally as important to monitor resident's adverse reaction to medication as they could go into an anaphylactic shock (blood pressure drops suddenly and the airways narrow, blocking breathing), get extremely sick and or die. In an interview with RN on 6/20/24 at 2:40am stated that all the orders must be followed, and documentation must be completed in PCC, EMAR, ETAR and initialed when medications are administered. RN stated, the missing documentation on 6/8/2024 should never occurred and there is no excuse for not documenting and following physician orders. In an interview with LVN B on 6/21/24 at 9:30am stated she worked 6/7/2024 6am - 2pm shift, but she worked on a different resident hall. She stated the PCC, EMAR/ETAR systems were working, and she did not experience any interferences in the computer system. She stated she had no complaints. LVN B stated documentation is a required practice for nurses as it shows what you've done, talks about the resident, change of conditions and reports problems to others. LVN B stated if it's not documented it didn't happen. LVN B stated she documents as she goes to eliminate being sidetracked. She further statedshe reports to the weekend nurse manager if there are any issues with residents and if there was an issue with the PCC system, she would immediately report it. In an interview with LVN C on 6/21/24 at 10:10am she stated she worked 6/7/2024 on 6am - 2pm shift on 6/7/2024. She was assigned to hallway 500. She stated she did not have any issues with documentation in the PCC, EMAR/ETAR or system failure that prevented the required electronic documentation in the PCC system. LVN C stated sometimes there was limited reception in the 500 hallway, where documenting may not post in the resident's file, but nurses are aware of the limited reception in the entrance of the hallway, so they just walk a few steps away and then document. She stated it is important to document to show residents are receiving care and any type of change of conditions. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility's Medication -Treatment Administration and Documentation Guidelines policy dated 1/9/2014 and revised 4/6/2023 Revealed the follow: #4- administer the medication according to the physician order. #5-Document e-signature for medications and treatments administered on the EMAR or ETAR immediately following administration. #7- Medications or treatments that were not administered should be documented as not administered on the EMAR/ETAR with the reason for the not administration.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on interviews and record reviews, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 Residents (R #1), reviewed for medical records accuracy, in that: 1.The facility failed to document Resident #1's 8:00am blood sugar levels were checked by AccuCheck two times day for diabetes mellitus by LVN A. 2.The facility failed to document Resident #1 received his Vital signs and record in PCC during LVN A 6:00am-2:00pm shift. 3.The facility failed to document Resident #1 was monitored for an Adverse Drug Effects during LVN A 6:00am-2:00pm shift. 4.The facility failed to document Resident #1 was monitored for an Adverse Drug Effects Anticoagulant Monitoring during LVN A 6:00am-2:00pm shift. 5.The facility failed to document Resident #1's was monitored for Adverse Antidepressant Medication during LVN A 6:00am-2:00pm shift. 6.The facility failed to document Resident #1's was monitored for Adverse Antidiabetic Medication during LVN A 6:00am-2:00pm shift. 7.The facility failed to document Resident #1's was monitored for Adverse Cardiac Medications (blood pressure medications, beta blockers) during LVN A 6:00am-2:00pm shift. 8.The facility failed to document Resident #1's Catheter stabilizer was in place and secure during LVN A 6:00am-2:00pm shift. 9.The facility failed to document Resident #1's suprapubic site was cleaned and pat dry then place a split gauze on site during LVN A 6:00am-2:00pm shift. 10.The facility failed to document Resident #1's head of bed elevated to 30 degrees during LVN A 6:00am-2:00pm shift. 11.The facility failed to document Resident #1 was evaluated for pain during LVN A 6:00am-2:00pm shift. 12.The facility failed to document Resident #1's was monitored for Adverse Insulin Therapy effects during LVN A 6:00am-2:00pm shift. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings included: Review of R#1's face sheet revealed he was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident was diagnosed with type 2 Diabetes Melltus without complication (prevents the body from producing insulin), Hypertension (high blood pressure), chronic kidney disease (kidneys are damage and can't filter blood), peripheral vascular disease (slow progressive disorder or the blood vessels). Review of R#1 orders revealed, (insulin Glargine)-Inject 15 units subcutaneously in the morning; (orders start 6/8/23 at 6:30am); Accu Checks blood levels two times a day for DM (diabetes Mellitus (orders Start 1/28/23 at 8:00am); Vital signs twice daily and record in PCC (electronic health record) every day and evening shift (order Start 11/14/2022); Adverse drug event monitoring by licensed nurse, every shift, to observed resident for side effects from taking an Anticoagulant, antidiabetic and cardiac medication, which could cause excessive bleeding, blood pressure issues; Check catheter (a tube inserted into bladder, allowing urine to drain freely) for infection and trauma (order Start 8/16/2019); Elevate head of bed to >30 degrees at all times every shift (order Start 1/26/2016). Review of R#1's annual MDS assessment, dated 5/19/2024 revealed BIMS of 03, which indicates severe cognitive impairment. Review of R #1's care plan dated 10/31/2018 was at risk for pain r/t stage 4 pressure ulcer and administered meds as ordered by MD (medical doctor) (initiated 3/2/2018 and revision on 4/11/2023), Catheter care every shift cleanse site daily and apply dry dressing daily (date initiated 7/24/2015), resident is currently taking antihypertensive medication which should be administered as ordered. Monitor for side effects such as orthostatic hypotension, headache, vertigo, chest pain, and decreased heart rate (Bradycardia); give medications for improved blood flow or anticoagulants as ordered Plavix 75mg QD (initiated 7/24/2015 and revision 6/3/2021); resident is at risk for unstable blood sugars related to type II diabetes (Insulin-date initiated 7/24/2015 revision 6/19/2023)-Administer diabetes medications as ordered by the physician and monitor for adverse reactions and report as detected. Review of R#1's electronic nursing notes revealed no nursing documentation at all in R#1's notes between 6/6/2024 at 2:06pm and 6/13/2024 5:05pm. MAR revealed no vital signs or monitoring resident for adverse medication effects on 6/8/2024 during the 6:00am-2:00pm. In an interview with LVN A on 6/20/24 at 1:09pm, she was working the 6am-2pm shift on 6/8/2024. Also during the interview with LVN A, she stated she was assigned and worked the 500 hall. LVN A stated she administered medication and documented in the EMAR/ETAR during her shift. LVN A stated she has no idea and does not know why there was no documentation in the resident's orders or in PCC during her shift. LVN A stated there must have been an issue in getting service on the 500 hall area. LVN A stated it was important to document along with following the physician orders regarding residents' conditions. She further stated it was equally as important to monitor resident's adverse reaction to medication as they could go into an anaphylactic shock (blood pressure drops suddenly and the airways narrow, blocking breathing), get extremely sick and or die. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN on 6/20/24 at 2:40am stated that all the orders must be followed, and documentation must be completed in PCC, EMAR, ETAR and initialed when medications are administered. RN stated, the missing documentation on 6/8/2024 should never occurred and there is no excuse for not documenting and following physician orders. In an interview with LVN B on 6/21/24 at 9:30am stated she worked 6/7/2024 6am - 2pm shift, but she worked on a different resident hall. She stated the PCC, EMAR/ETAR systems were working, and she did not experience any interferences in the computer system. She stated she had no complaints. LVN B stated documentation is a required practice for nurses as it shows what you've done, talks about the resident, change of conditions and reports problems to others. LVN B stated if it's not documented it didn't happen. LVN B stated she documents as she goes to eliminate being sidetracked. She further statedshe reports to the weekend nurse manager if there are any issues with residents and if there was an issue with the PCC system, she would immediately report it. In an interview with LVN C on 6/21/24 at 10:10am she stated she worked 6/7/2024 on 6am - 2pm shift on 6/7/2024. She was assigned to hallway 500. She stated she did not have any issues with documentation in the PCC, EMAR/ETAR or system failure that prevented the required electronic documentation in the PCC system. LVN C stated sometimes there was limited reception in the 500 hallway, where documenting may not post in the resident's file, but nurses are aware of the limited reception in the entrance of the hallway, so they just walk a few steps away and then document. She stated it is important to document to show residents are receiving care and any type of change of conditions. Record Review of the facility's Medication -Treatment Administration and Documentation Guidelines policy dated 1/9/2014 and revised 4/6/2023 Revealed the follow: #5-Document e-signature for medications and treatments administered on the EMAR or ETAR immediately following administration. #7- Medications or treatments that were not administered should be documented as not administered on the EMAR/ETAR with the reason for the not administration.