

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49157</p> <p>Based on observation, interview, and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for two of five residents (Resident #1 and Resident #2) reviewed for abuse.</p> <p>The facility failed to ensure Resident #1 was free from abuse. On 09/28/24, Resident #2 pushed Resident #1 backward. Resident #1 tripped, then fell and hit the back of her head on the floor which resulted in a hematoma (swelling) to the back of her head.</p> <p>This failure could place residents at risk for abuse and physical, mental, and psychosocial harm.</p> <p>The findings included:</p> <p>1. Record review of Resident #1's admission record reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included dementia (several diseases that affect memory, thinking, and the ability to perform daily activities, Alzheimer's (a progressive disease that destroys memory and other important mental functions), blindness left eye, muscle wasting and atrophy (decreased muscle size and strength), gait abnormality (abnormal walking pattern) and lack of coordination.</p> <p>Record review of Resident #1's annual MDS, dated [DATE], reflected a BIMS score of 1, which indicated Resident #1 had severe cognitive impairment.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #1's comprehensive care plan, dated 01/13/23 to 01/24/25, reflected Resident #1 was an elopement risk, had a behavior of wandering into other resident's rooms and was appropriate for placement in the secure unit r/t dementia. Resident #1 had a behavior problem r/t dementia and would become physically aggressive when staff assisted with hygiene and ADLs. Resident #1 had an actual fall on 9/28/24 with minor injury r/t resident to resident altercation after Resident #1 wandered into Resident #2's room. Interventions prior to the incident included distract resident from wandering by offering pleasant diversion, structured activities, food, conversation, television, or a book, and she would be redirected when she wandered into other residents' rooms initiated 01/16/23 and refer resident for psychiatric services and medication management initiated on 02/19/24. Interventions after the altercation included administer medications as ordered and monitor/ document for side effects and effectiveness, caregivers to provide opportunity for positive interaction and attention with resident by stopping and talking with her when passing by and intervene as necessary to protect the rights and safety of others by approaching/speaking in a calm manner, diverting attention, and removing from the situation as needed initiated on 10/01/24.</p> <p>2. Record review of Resident #2's admission record reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included schizophrenia (a disorder characterized by hallucinations-seeing or hearing things that aren't real, disorganized thinking, and disorganized speech), schizoaffective disorder, bipolar type (a combination of the symptoms of schizophrenia and manic episodes (periods of extreme energy and impulsivity) and depressive episodes (periods of sadness, loss of interest, or fatigue).</p> <p>Record review of Resident #2's quarterly MDS prior to the altercation dated 07/03/24 reflected a BIMS score of 11 which indicated Resident #2 had moderate cognitive impairment.</p> <p>Record review of Resident #2's comprehensive care plan, dated 03/08/24, reflected Resident #2 had behavior problems of making accusations toward staff, physical and verbal aggressiveness towards others, r/t poor impulse control, ineffective coping skills, and mental/ emotional illness. Resident #2 was an elopement risk and was appropriate for placement in the secure unit r/t schizophrenia and elopement risk. Resident #2 was physically aggressive with Resident #1 on 09/28/24 . Interventions prior to the incident included assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and remove from situation initiated on 03/08/24 and analyze/document the circumstances and de-escalation techniques regarding the resident's physical aggression and provide physical and verbal cues to alleviate anxiety, assist the resident in verbalization of source of agitation, setting goals for more pleasant behavior, encouragement to seek out a staff member when agitated initiated on 04/30/24 and referral to psychiatric services on 06/25/24. Interventions after the incident included all of the prior interventions as well as continue psychiatric services, continue medications to reduce anxiety and promote relaxation every 8 hours as needed initiated on 10/01/24.</p> <p>Record review of the facility's reported incident report, dated 09/29/24, reflected Resident #2 stated, [Resident #1] was going into my room to get my things. I stood at the door to deny her entrance, so she grabbed me by my neck, so I pushed her, and she fell to the floor. The facility reported incident also reflected Resident #1 was not able to say what happened.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #1's progress notes, dated 09/28/24 at 4:00 pm, reflected an entry that stated, CNA heard a loud thump in the hallway and noted resident (#1) on the floor on her back in front of another resident's room. Resident (#1) was unable to give details as to what happened.</p> <p>Observation on 02/04/25 from 3:58 pm to 4:14 pm of Resident #1 and Resident #2 in the secured unit of the facility reflected Resident #1 was in her bed with eyes closed and appeared to be asleep. Resident #2 was in the common room with other residents watching television. Resident #2 would occasionally interact with other residents and staff with no aggressive behavior.</p> <p>In an interview on 02/04/25 at 3:58 pm, LVN C stated she had been employed at the facility for a week and had not seen or heard Resident #2 be aggressive with Resident #1 or any other residents. LVN C stated Resident #2 would tell her she was hearing voices and LVN C would talk with her to ensure she was not a risk to herself or any of the other residents.</p> <p>In an interview on 02/05/25 at 11:02 am, ADON E stated Resident #1 was a wanderer and on 09/29/24, Resident #1 wandered into Resident #2's room and Resident #2 told her to get out. Resident #1 would not leave, so Resident #2 pushed Resident #1 who tripped and hit her head. ADON E stated she did not recall if Resident #1 went to the hospital. ADON E stated Resident #1 was redirected often in her wandering; sometimes it worked, sometimes it did not. ADON E stated sometimes Resident #1 got agitated so they got another staff member to convince her to come out and listen to music or something. ADON E stated Resident #1 was redirected as needed and there had not been any other incidents with her that she could recall. ADON E stated Resident #2 had a few other incidents with other residents previously, but she did not recall any incidents since this one with Resident #1. ADON E stated Resident #2 said her voices told her to do things and she was on psychiatric services and psychiatric medications to help control the voices. ADON E stated the secured unit had 1 nurse and 2 aids working as well as the activities assistant who worked with the residents during the day. ADON E stated staff were in-serviced on ANE and misappropriation at least monthly and more frequently as needed and the last in-service was last week.</p> <p>In an interview on 02/04/25 at 4:15 pm, Resident #2 stated she felt safe here and liked the staff. Resident #2 stated she got along with the other residents and did not have any issues with anyone.</p> <p>Record review of the facility's in-service records reflected staff had an in-service on abuse and neglect as well as resident rights on 09/30/24.</p> <p>Record review of the facility's Abuse and Neglect-Clinical Protocol policy dated 03/2018 reflected:</p> <p>4. Willful, as used in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>Assessment and Recognition:</p> <p>4. The physician and staff will help identify risk factors for abuse within the facility; for example, significant numbers of residents/patients with unmanaged problematic behavior.</p> <p>Cause Identification:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>1. The staff, with the physician's input as needed, will investigation alleged abuse and neglect to clarify what happened and identify possible causes.</p> <p>Treatment/Management:</p> <p>1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.</p> <p>4. The physician and staff will address appropriately causes of problematic resident behavior where possible, such as mania, psychosis, and medication side effects.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49157</p> <p>Based on observation, interview, and record review the facility failed to ensure each resident had the right to be free from abuse, neglect, misappropriation of property, and exploitation for 1 of 6 residents (Resident #3) reviewed for misappropriation of property.</p> <p>The facility failed to prevent the misappropriation of Resident #3's lorazepam (a controlled medication [benzodiazepine] used to relieve symptoms of anxiety) and Tramadol (a schedule IV controlled opioid medication used to treat pain) tablets.</p> <p>This failure could place residents at risk for not receiving prescribed medications which could lead to physical, mental, or psychosocial harm.</p> <p>The findings included:</p> <p>Record review of Resident #3's admission record reflected an [AGE] year-old female, who was admitted to the facility on [DATE]. She had diagnosed which included dementia (the loss of cognitive functioning), anxiety disorder (a mental health disorder characterized by feelings of worry, fear, or nervousness that are strong enough to interfere with a person's daily activities), stiffness to right shoulder, broken nasal bones, and muscle weakness.</p> <p>Record review of Resident #3's admission MDS assessment, dated 01/17/25, reflected based on Section C: Cognitive Patterns, the resident had a BIMS score of 1, which indicated severe cognitive impairment. Based on Section N: Medications, the resident received an antianxiety medication.</p> <p>Record review of Resident #3's comprehensive care plan reflected a Focused area, initiated on 01/10/25, of pain medication therapy r/t stiffness of right shoulder, fracture of nasal bones, and age related osteoporosis (a condition in which the bones become weak and brittle) with pathological fracture (broken bone caused by the weakness of the bone structure). The goal initiated on 01/10/25, was that the resident would be free of any discomfort or adverse side effects from pain or medication through the review date. The interventions, initiated 01/10/25, were staff were to administer pain medications as ordered by the physician and review frequently for pain medication effectiveness.</p> <p>Record review of Resident #3's January 2025 eMAR reflected the physician's order for Lorazepam 1mg, 1 tablet to be given by mouth every 4 hours as needed for anxiety or agitation and Tramadol 50mg, 1 tablet to be given by mouth every 6 hours as needed for pain. For both medications the order start date was 01/11/25 and stop date was 01/15/25.</p> <p>Record review of the facility's self-reporting template, dated 01/15/25, reflected an allegation of misappropriation of property occurred on 01/13/25. The alleged victim was Resident #3 who all allegedly had 7 lorazepam tablets and 19 tramadol tablets misappropriated. The self-reporting template did not name an alleged perpetrator.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review on 02/04/25 of the controlled drug receipt/record/disposition form for Resident #3's Lorazepam reflected the facility received 25 tablets of Lorazepam on 01/10/25. The controlled drug receipt/record/disposition form reflected that the starting count of Lorazepam 1mg tablets was 25 tablets. This form also reflected 1 tablet of Lorazepam 1mg was administered to Resident #3 as follows:</p> <p>01/10/25 at 8:00pm by LVN N with 24 tablets remaining.</p> <p>01/11/25 at 1:30am by LVN N with 23 tablets remaining.</p> <p>01/11/25 at 9:00am by LVN B with 22 tablets remaining.</p> <p>01/11/25 at 5:00pm by LVN B with 21 tablets remaining.</p> <p>01/11/25 at 10:00pm by LVN J with 20 tablets remaining.</p> <p>01/12/25 at 2:00am by LVN J with 19 tablets remaining.</p> <p>01/12/25 at 7:00pm by LVN N with 18 tablets remaining.</p> <p>01/12/25 at 11:00pm by LVN N with 17 tablets remaining.</p> <p>01/13/25 at 4:00am by LVN N with 16 tablets remaining.</p> <p>01/13/25 at 10:00am by LVN I with 15 tablets remaining.</p> <p>Record review on 02/04/25 of the controlled drug receipt/record/disposition form for Resident #3's Tramadol reflected the facility received 54 tablets of Tramadol on 01/10/25. The controlled drug receipt/record/disposition form reflected the starting count of Tramadol 50mg tablets was 54 tablets. The form also reflected 1 tablet of Tramadol 50mg was administered to Resident #3 as follows:</p> <p>01/10/25 at 8:00pm by LVN N with 53 tablets remaining.</p> <p>01/11/25 at 2:00am by LVN N with 52 tablets remaining.</p> <p>Record review of ADON D's, undated, typed statement to the facility reflected:</p> <p>To whom it may concern on 1/13/24 @ about 4:18 pm I was in the 300 hall assisting [LVN G] with [Resident #3], and I called [LVN I] via phone to bring all medications for [Resident #3] who was just transferred from 200 hall to 300 hall earlier in the day, I instructed the CNA to take [Resident #3] to activities and doorbell rang to secured unit [LVN G] was on phone so I went to answer Secured unit door where [LVN I] handed me a purple bag of Resident medications I then walked to nurses station with purple bag in hand and left purple bag with [LVN G] at nurses station.</p> <p>Typed name [ADON D]</p> <p>Signature of ADON D [sic]</p> <p>Record review of LVN F's written statement that was e-mailed to the facility on [DATE] reflected:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>To Whom it May Concern-</p> <p>On January 13, 2025, I worked an overnight shift from 10-6 and relieved [LVN H]. Throughout the evening I noticed [Resident #3] was restless and had increased anxiety. After looking at her MAR I noticed that she did have medications to assist with decreasing her anxiety. I then looked in narcotic box for her medications and she did not have medications other than ABH cream. I then went to 200 hall nurses to see if medications were in their cart as a patient was recently moved into the 300 unit that day and medications were possibly left behind. Approached [LVN J] regarding medications and he stated he didn't have them wither [sic] and they were transferred to 300 halls earlier in the day when patient was moved. I informed [LVN J] that the medications were not in 300, he then looked in his medication cart and then assisted me in again looking in 300 hall cart- to which medications were not seen. He then began stating when patient came from home her medications were sent in a purple bag, I then began looking around nurses' station, cabinets, medication room, in patients' room and patients' prior room for bag and/or medications to where they were not found. [LVN J] then notified on call nurse regarding medications missing. At approximately 0530 in the morning both ADONs [ADON D and ADON E] entered 300 and also began looking for medication. At 6am on coming nurse asked for keys to medication room, unlocked door and found purple bag with medications in it. Report was given; narcotics that were in the narcotic drawer were counted. When this nurse was leaving the day shift nurse was on the phone with ADON and stated that narcotics were in the bag, this nurse then left shift.</p> <p>[LVN F]</p> <p>[phone number]. [sic]</p> <p>Record review of LVN G's written statement to the facility, dated 01/14/25, reflected:</p> <p>I, [LVN G] Charge Nurse on 300 hall took the bag of home medication for a resident transferring from 200 hall without examining the medications and placed them in the Nurse's cart and locked it. [sic] It was signed by [LVN G] with the date 1/14/25 below the signature.</p> <p>Record review of LVN H's written statement to the facility, dated 01/16/25, reflected:</p> <p>I was called to [DON's] office at 11:20 am where I spoke with the DON and [Admin]. I was asked about medications for patient [Resident #3]. When asked which narcotics she had I stated Abd [sic] gel, that was only narcotic in drawer when I went to administer meds and saw she had Vimpat and another narc. Tramadol. I called 200 hall spoke w/ [LVN J] to ask if they were still on order should come in tonight. So I clicked them out as not administered. I did see a purple bag next to clients [sic] cigarettes in med room but did not go through it. Signed by [LVN H] with 1-16-25 under signature.</p> <p>Record review of LVN I's e-mailed statement to the facility, dated 01/20/25, reflected:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A resident of mine was transferred from my hall on 200 to 300, around 4pm I was called by [ADON D] and asked to take all of the residents' medications to 300 hall. I packed all of the residents' medications in a purple zipper bag (that belonged to the resident) and walked the medications to 300 hall. I rang the doorbell, [ADON D] answered the door and I handed the bag of medication to him and returned to my hall. The following morning after clocking into work, I walked in the hallway and ran into [ADONs D and E], I was asked if I had administered any medication to the resident the day prior to which I responded that I did. I was also asked if the count for the medication was correct when I received the drawer the morning prior to which I answered yes. After that they informed me that medications were missing or lost from the resident's purple bag that I had given [ADON D]. I told [ADONs E and D] that I was unaware of what happened to the medication and that the count was correct when I left them with [ADON D]. [sic]</p> <p>Observation of the 300 hall medication room on 02/04/25 at 4:00 pm reflected a wooden cabinet measuring approximately 24 inches tall by 30 inches wide to the left of the doorway at approximately shoulder height. There was a keyed lock on the cabinet, but it was not locked. LVN C stated she had never seen the cabinet locked. In the cabinet on the left side there was a sealed box that had [NAME] on it, another box that resembled the first box, but was not facing out, and an opened box on top that had OHC and OHC COVID -19 Antigen Self-Test on it. On the back wall of the cabinet was a white spray bottle approximately 3 inches tall, facing the back wall of the cabinet, a clear spray bottle approximately 4 inches tall that was full of a blue liquid with the word Fresh visible and a humidifier bottle in a plastic bag. In the back right corner of the cabinet there were 4 pill bottles with over the counter medications in them that were sealed. There was a glucometer in the front right corner of the cabinet.</p> <p>In an interview on 02/04/25 at 3:13 pm, LVN A stated when a resident was admitted and they had medications, the nurse looked at the medications, asked the resident or representative if they were current medications and confirmed the order with the physician. LVN A stated when they received a narcotic medication from the resident a drug receipt/record/disposition form was filled out and was utilized when the resident was given their home narcotic medication. LVN A stated narcotic medication administration was documented in the eMAR and on the narcotic log sheet. LVN A stated he did not recall Resident #3 specifically but if a resident was transferred to another hall, he would count the narcotic medication and verify it with the receiving nurse, but they did not sign the narcotic log sheet. LVN A stated it was just visually verified by both nurses. LVN A stated the last in-service on medication administration/documentation was within the last month and they were in-serviced about every 3 months. LVN A stated they were in-serviced on abuse/neglect/misappropriation/resident rights frequently.</p> <p>In an interview on 02/04/25 at 3:44 pm, LVN B stated when a resident came in with medications, they would get a list of the medications and if there were narcotics, 2 nurses would count them and sign them into the narcotic lock box on the medication cart and put them on the narcotic log. LVN B stated the facility administered the resident's home narcotics when there was an order for them and once the pharmacy delivered the resident's narcotics, if there were any of the resident's narcotics remaining, the medications were given to the ADONs to destroy, and the narcotic sheets were given to them to file. LVN B stated if a resident transferred to another hall, the transferring nurse would count the narcotics with the receiving nurse, and they would both sign the narcotic form that was put in the narcotic log for the receiving hall. LVN B stated the last in-service on abuse/neglect/resident rights/misappropriation was within the last couple of weeks and medication administration/documentation was about 3 weeks ago.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/04/25 at 3:58 pm, LVN C stated if a resident came in with narcotics, 2 nurses would count it, a narcotic log page was made, and 2 nurse signed it and put it into the narcotic logbook for that hall. LVN C stated the narcotics always had to be locked up in the medication cart lock box and not put into the medication room because there was no way to secure them there. LVN C stated it was the same procedure if the resident came from another hall. LVN C stated she would verify with the physician if the medication was to be continued. LVN C stated if a narcotic medication was to be discontinued, the medication was given to the DON to dispose of. LVN C stated the facility would try to use up the resident's home narcotics because the pharmacy would not send narcotics if it was not time for a refill.</p> <p>In an interview on 02/04/25 at 4:32 pm, ADON D stated if a resident was admitted with narcotics, he counted them with another nurse, got a narcotic sheet to document it, put the sheet into the main narcotic log, then locked them up in the narcotic box on the medication cart. ADON C stated the doctor was contacted to confirm orders. ADON D stated the physician had the facility use up the resident's home narcotics so the narcotic script could be filled. ADON D stated if a resident transferred from one hall to another, the sending nurse took both the narcotic and non-narcotic medications and narcotic sheet(s) to the receiving nurse, they would verify the count and then locked the narcotics up in the medication cart lock box for the hall the resident was transferred to. ADON D stated he was in the 300 hall on 01/13/25 to help LVN G because she was passing medications and the CNAs were busy, so he went to help watch Resident #3, as she kept trying to get up and walk but was not safe to walk. ADON D stated Resident #3's medications were handed to him in a purple zipper bag that belonged to Resident #3 by LVN I on 01/13/25 at approximately 4:15 pm. ADON D stated LVN I did not take any narcotic sheets to him, so he was not aware there were narcotics in the purple zipper bag. ADON D stated he handed the bag to LVN G and left the unit. ADON D stated he was not sure what LVN G did with the medications. ADON D stated the Admin and DON may have reviewed the camera footage, but he was not sure. ADON D stated Resident #3 transferred from the 200 hall to the 300 hall within the previous hour of when he received the medications from LVN I. ADON D stated ADON E was the on call for the night on 01/13/25 early morning on 01/14/25 and she notified him of the missing narcotics at approximately 5:00 am on 01/14/25. ADON D stated he and ADON E arrived at the facility around 6:00 am. ADON D stated he called LVN G before he went to the facility, and she told him she put the bag inside the medication cart. ADON D stated he went to the 300 hall with LVN F, checked the medication cart and Resident #3's medications were not there so he stopped the medication pass to do a narcotic count and there were no missing narcotics on the cart. ADON D stated he did not check the unit or the medication room for the missing purple bag. ADON D stated the narcotic sheets were found at the 200 hall nurse's station the morning of 01/14/25. ADON D stated when he told ADON E they could not find the medications, ADON E had the narcotic sheets for the missing narcotics but also had not located the medications. ADON D stated LVN G called to let them (him and ADON E) know she found the bag inside the medication room in the cubby area so he and ADON E went back to the 300 hall to count those specific medications (lorazepam and tramadol) and was when they discovered the 7 missing lorazepam and 19 missing tramadol. ADON D stated they then notified the DON, Resident #3's responsible party, and the physician. ADON D stated he thought the DON may have the lorazepam and tramadol narcotic pages in his office now. ADON D stated the pharmacist came in monthly to destroy narcotics. ADON D stated when the physician discontinued a medication, it was discontinued in PCC, then narcotics went to the DON and were locked up until the pharmacist went to the facility for narcotic destruction. ADON D stated they did in-services on ANE at least monthly and usually more frequently and the last in-service was within the last couple of weeks.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/05/25 at 9:46 am, the DON stated ADON E called him on 01/14/25 and said there was potentially a drug diversion. The DON stated he went into the facility and had her tell him what happened. The DON stated after ADON E told him there were narcotics missing, he, and ADONs D and E checked all of the medication carts to make sure no other narcotics were missing. The DON stated he got Resident #3's medications and narcotic sheets and there was no way to account for the 7 missing lorazepam tablets and 19 missing tramadol tablets, so he reported it to the Admin. The DON stated after notifying the Admin, he called every nurse involved and got their statement. The DON stated after getting all of the nurse's statements, he and the Admin compared statements, looked at the video feed and determined LVN H's statement did not match what the video showed. The DON stated it was then reported to the state survey agency, LVN H was suspended and then terminated. The DON stated they did an in-service with staff to make sure everyone knew how to transfer residents and their medications, specifically narcotics, to another hall. The DON stated when they told LVN H they were going to suspend her, she just said, OK. The DON stated LVN H did not offer any explanation or argument and he did not get the opportunity to talk to her after that because she was terminated right away. The DON stated LVN G was the morning nurse who came in on 01/14/25 and found the purple bag with the medications. The DON stated the nurses usually worked 12-hour shifts, but on 01/13/25, LVN H worked as a medication aide in the 100 hall during the day (6:00am to 6:00pm), then transferred to the 300 hall to work as a nurse until 10:00 pm, then LVN F worked 10:00 pm to 6:00 am. The DON stated LVN F was looking for the narcotic sheet for Resident #3's ABH cream (a cream containing Ativan (brand name for lorazepam, a controlled antianxiety medication), Benadryl (brand name for diphenhydramine, a non- controlled antihistamine), and Haldol (brand name for haloperidol, a controlled antipsychotic), so she called the 200 hall and LVN J took the sheet to her. The DON stated LVN F told him neither the lorazepam or tramadol were in the 300 hall medication cart nor were the narcotic log sheets for those medications. The DON stated the purple bag was found in the 300 hall medication room in a closed cabinet and the narcotic log sheets for the lorazepam and tramadol were found in the ADON basket in the 200 hall that was for records to be scanned. The DON stated ADON E found the log sheets and LVN G found the medication bag. The DON stated the video showed on 01/13/25 around 9:20-9:30 pm, LVN H was on the facility phone, hung up, turned around, opened the next to bottom drawer of the medication cart, looked inside, closed it, then opened the bottom drawer of the medication cart, took the purple bag out of it, stood up and placed the purple bag on top of the cart, opened the purple bag, then picked up and read the labels of each of the medication bottles that was inside. The DON stated LVN H then took the whole purple bag in the medication room and came out with nothing. The DON stated at the end of LVN H's shift, she and LVN F counted the narcotics in the medication cart and LVN H left. The DON stated he could not remember if LVN H worked on the 14th or 15th and she worked primarily in the 300 hall. The DON stated when narcotic medications were administered, the nurse was supposed to document it on the narcotic log as well as on the eMAR. The DON stated his expectation was that nurses documented accurately and timely when medications were administered.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/05/25 at 11:02 am, ADON E stated on the night of 01/13/25 (the early morning hours of 01/14/25) she was asked by LVN J, the night shift 200 hall nurse (by call or text, she could not remember which) sometime in the middle of the night, if a day shift nurse had handed her the bag of medications for Resident #3 and she told him no. ADON E stated LVN J told her he would look around there to see if he could find them. ADON E stated she woke up to a text message that LVN J had reached out to the day nurse, LVN I, and he was waiting for a response from her. ADON E stated she then called ADON D and let him know LVN F and LVN J could not find Resident #3's purple bag of medications and they should probably go in and do a narcotic count and help look for the missing medications. ADON E stated when she and ADON D got to the facility, she went to the 200 hall where LVN J was and he showed her the control sheets for the lorazepam and tramadol were in the ADON box which was the box for any paperwork that needed to go to medical records to get scanned into PCC. ADON E stated LVN J had already taken the narcotic sheets out of the box and put them on the nurse's station desk to show her the narcotic sheets were there, but the narcotics were not. ADON E stated she and LVN J verified the narcotic count in the 200 hall side 1 and side 2 nurse medication carts and the 200 hall medication aide cart and there were no discrepancies, nor was the purple bag of medications found. ADON E stated she and LVN J also checked the 200 hall medication room and did not find the missing medications. ADON E stated ADON D had already finished the 100 hall so they both went to the 300 hall. ADON E stated she took the control sheets with her, and LVN G called ADON D and told him she found the purple bag. ADON E stated LVN G told them it was in the 300 hall medication room in a cabinet. ADON E stated LVN G opened the bag while she and ADON D were watching, went through the bottles, emptied the lorazepam bottle onto the counting tray, asked how many tablets were supposed to be there and the count was short by 7 tablets. LVN G put the tablets back into the lorazepam bottle, set it aside, then counted the tramadol which was short by 19 tablets. ADON E stated she and ADON D recounted both medications 2 times to confirm the amount missing. ADON E stated she and ADON D called the Admin and the DON to let them know. ADON E stated the DON asked them to secure the 2 medication bottles, so they were locked in the 300 hall narcotic box until he got there. ADON E stated they then handed the bottles of lorazepam and tramadol and the count sheets to the DON. ADON E stated neither she nor ADON D saw LVN G find the bag, she just told them she found it. ADON E stated she had asked LVN I if she remembered if she took the medications and the narcotic sheets over to the 300 hall she said she did not send them over. ADON E stated when the Admin and the DON arrived, she handed the investigation over to them. ADON E stated LVN H had worked at the facility less than 6 months, and LVN G had been there for 1 to 2 years. ADON E stated there had not been any other missing medication incidents with either LVN G or LVN H prior to this. ADON E stated there were no indications that LVN H had ever gone to work under the influence. ADON E stated the facility did not drug test prior employment. ADON E stated they did an in-service regarding the policy of transferring medications with a resident to another hall and the rule was to count the narcotics and sign the narcotic log sheet with 2 nurses. ADON E stated medication administration and medication storage was in-serviced once every month or three months and as needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 02/05/25 at 11:54 am, LVN F stated she went in at 10:00 pm on 01/13/25 and got report on a resident (Resident #3) who transferred into the unit that day. LVN F stated that night Resident #3 was restless, and she gave Resident #3 the ABH cream already. LVN F stated she checked Resident #3's eMAR and saw she had other medications available PRN for anxiety and agitation. LVN F stated at about 1:00 am, she went over to the 200 hall and asked LVN J about Resident #3's PRN medications for anxiety and agitation. LVN F stated LVN J looked in his cart and told her he did not find the medications but did find the sign off sheets for the PRN lorazepam and tramadol. LVN F stated LVN J told her when Resident #3 was admitted she had her medications in a purple bag. LVN F stated she went back to the 300 hall and looked for the PRN medications in the medication room where she went through the cabinets and shelves, then went through the nurse's station drawers, looked all through the medication cart and even checked the floors. LVN F stated she also went to Resident #3's 300 hall room and to her previous 200 hall room to look but did not find any medications or the purple bag. LVN F stated at about 1:30 am, LVN J called the on call nurse to let them know that neither he nor LVN F could find Resident #3's medications. LVN F stated the ADON D and ADON E got to the facility at about 5:30 am (on 01/14/25) and they started looking for the medication. LVN F stated ADON D said he gave this purple bag to the day shift nurse on 01/13/25. LVN F stated she did not know anything about those medications, and they were not counted when she went on shift at 10:00 pm. LVN F stated ADON D and ADON E left the 300 hall and LVN G came in for shift change. LVN F stated when she was trying to give LVN G report, LVN G asked for the keys to the medication room then came out and said she found the bag in a wooden box; she opened the door to the box and the bag was in there. LVN F stated she felt like she had checked there, and the bag was not there, but maybe she missed it. LVN F stated she and LVN G had already done the narcotic count on the medication cart and signed off before LVN G went into the medication room and found the bag. LVN F stated LVN G told her, Yesterday was a crazy day. LVN F stated she felt like LVN G may have already known those medications were being looked for. LVN F stated as soon as LVN G walked into the medication room, she opened the box thing and then walked out with the bag. LVN F stated the usual process was when the resident transferred, their medications and narcotics were given directly to the receiving nurse from the sending nurse and the narcotics were counted and signed for by both nurses. LVN F stated anytime narcotics were given, it was documented in the narcotic log and in the eMAR.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 02/05/25 at 12:46 pm, LVN G stated 01/13/25 was a very busy day when Resident #3 was transferred to the 300 hall. LVN G stated she was on the phone when Resident #3's medication was taken over to her. LVN G stated ADON D took the ABH cream out of the purple bag and told her that it belonged to Resident #3. LVN G stated she put the ABH cream in the lock box on the medication cart, but there were no narcotic documentation sheets. LVN G stated she finished what she was doing and put the purple bag in the cart, but not in the narcotic box part. LVN G stated she put the purple bag in the bottom drawer and did not look through it before she put it there. LVN G stated when things slowed down, she went to look for the ABH cream narcotic log sheet in the 200 hall. LVN G stated the night shift nurse, LVN J, gave her the ABH cream sheet. LVN G stated when she received Resident #3, They really did not give me report on her. I also did not have time to review her medications, so I did not know about the lorazepam and tramadol. LVN G stated she did not sign off on the ABH cream with any other nurses. LVN G stated the cream was in little packets and the count was correct according to the narcotic log sheet. LVN G stated LVN J did not tell her anything about Resident #3 having any other narcotics and no other sheets were given to her. LVN G stated she resigned on 01/14/25 because it was getting a little too much for her and she was getting frustrated. LVN G stated ADON E called her before she went to work on 01/14/25 and was asking her about Resident #3's medications. LVN G stated when she got to work, she got report from LVN F and did the medication cart check off with her. LVN G stated LVN F also asked about the lorazepam that was on the eMAR that could not be found. LVN F stated later on, she asked LVN H in person where the purple bag was and LVN F told her it was in the cabinet in the 300 hall where the cigarettes were kept. LVN G stated she went and found it and then told ADON D and ADON E that it was there. LVN G stated ADON E and ADON D told her the narcotic log sheets were found in the records box in the 200 hall. LVN G stated she did not know who found them. LVN G stated when the medications and the sheets were found, she, ADON D and ADON E did the count and found out it there were 7 missing lorazepam tablets and 19 missing tramadol tablets. LVN G stated when narcotics were given, it was documented on the eMAR and on the narcotic sheet in the narcotic log. LVN G stated they were in-serviced on medication administration and storage, specifically narcotics, at least annually and more frequently as needed. LVN G stated if she had known there were narcotics in the purple bag, she would have locked the narcotics in the lock box in the medication cart and made sure to find the sheets to them. LVN G stated when they brought Resident #3 into the 300 hall, She was just wiggling and everything. LVN G stated at that time, another CNA was visiting the 300 hall and she told her to watch Resident #3 while the other CNA was on break. LVN G stated she went to ADON D and E's office in the 100 hall to tell them Resident #3 needed to be a 1:1, and she could not do that with her. LVN G stated during the time she was talking to the ADONs in their office, Resident #3 had a fall. LVN G stated it appeared Resident #3 just slid off her chair, but it was still a fall. LVN G stated Resident #3 was near the nurse's station at a table but had managed to move around and slid out of her chair. LVN G stated when ADON D brought the purple bag to her and took out the ABH cream, she was on the phone with Resident #3's RP to tell her about the fall. LVN G stated, It had not been 5 minutes since they brought Resident #3 to the 300 hall that she fell. LVN G stated the 200 hall nurse brought Resident #3 to the 300 hall and told her she needed to be a 1:1, but LVN G felt she could not provide that. LVN G stated she put the ABH cream and the purple bag into the medication cart at the same time. LVN G stated on that particular day, there was only 1 CNA on the unit. LVN G stated normally there were 2, but someone called in and it was during the time the CNA went to do her rounds that Resident #3 fell.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 02/05/25 at 2:47 pm, LVN H stated on 01/13/25, It was a weird thing, I stayed over because LVN G did not want to stay and when I went over there it was a mess. LVN H stated Resident #3 was transferred to the 300 hall because she was trying to get out. LVN H stated LVN G told her they brought some of Resident #3's medications over, but not all of them. LVN H stated LVN G said there were still some narcotics belonging to Resident #3 in the 200 hall. LVN H stated LVN G told her they brought the ABH gel to the 300 hall, but none of the narcotic sheets. LVN H stated, It was a mess. Resident #3 had some of the medications there and some were not. LVN H stated when she documented the administration of Resident #3's nighttime medications, 2 were missing. LVN H stated when she called LVN J, he told her they were on order. LVN H stated, I grabbed the purple bag from the bottom of the med cart in the drawer and put it in the med room on the shelf to the left next to the med box. There were 2 or 3 meds that I clicked as not administered because she did not have them. When asked what medications were in the purple bag, LVN H stated, It was the famotidine and some others, but not the ones that were missing. When asked how many medications were in the purple bag, LVN H stated, I do not remember how many medications were in that bag. LVN H stated she moved the bag somewhere between 7:00pm and 9:00pm when s [TRUNCATED]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49157</p> <p>Based on observation, interview, and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 3 of 5 residents (Resident #3, Resident #4, and Resident #5) reviewed for accuracy and completeness of clinical records.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure administration of narcotic medication was accurately documented in the electronic medication administration record when Resident #3 received Lorazepam (a controlled medication [benzodiazepine] used to relieve symptoms of anxiety) 9 times between 01/10/25 and 01/13/25.</li> <li>2. The facility failed to ensure administration of narcotic medication was accurately documented in the electronic medication administration record when Resident #3 received Tramadol (a schedule IV controlled opioid medication used to treat pain) 2 times between 01/10/25 and 01/11/25.</li> <li>3. The facility failed to ensure administration of narcotic medication was accurately documented in the electronic medication administration record when Resident #3 received ABH gel (a cream containing Ativan (brand name for lorazepam, a controlled antianxiety medication), Benadryl (brand name for diphenhydramine, a non- controlled antihistamine), and Haldol (brand name for haloperidol, a controlled antipsychotic) 9 times between 01/11/25 and 01/14/25.</li> <li>4. The facility failed to ensure administration of narcotic medication was accurately documented in the electronic medication administration record when Resident #4 received Acetaminophen with codeine #3 (a schedule III controlled opioid medication used to treat pain) 33 times between 01/01/25 and 02/04/25.</li> <li>5. The facility failed to ensure administration of narcotic medication was accurately documented in the electronic medication administration record when Resident #4 received Tramadol (a schedule IV controlled opioid medication used to treat pain) 2 times between 01/23/25 and 01/29/25.</li> <li>6. The facility failed to ensure administration of narcotic medication was accurately documented in the electronic medication administration record when Resident #5 received Lorazepam (a controlled medication [benzodiazepine] used to relieve symptoms of anxiety) 4 times between 02/03/25 and 02/06/25.</li> </ol> <p>These failures could put residents at risk of improper medication administration based on inaccurate documentation.</p> <p>The findings included:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Record review of Resident #3's admission record reflected an [AGE] year-old female, who was admitted to the facility on [DATE]. Her diagnoses included dementia (the loss of cognitive functioning), anxiety disorder (a mental health disorder characterized by feelings of worry, fear, or nervousness that are strong enough to interfere with a person's daily activities), stiffness to right shoulder, broken nasal bones, and muscle weakness.</p> <p>Record review of Resident #3's admission MDS assessment, dated 01/17/25, reflected based on Section C: Cognitive Patterns, the resident had a BIMS score of 1, which indicated severe cognitive impairment.</p> <p>Record review of Resident #3's comprehensive care plan reflected a focused area, initiated on 01/10/25, of pain medication therapy r/t stiffness of right shoulder, fracture of nasal bones, and age-related osteoporosis (a condition in which the bones become weak and brittle) with pathological fracture (broken bone caused by the weakness of the bone structure). The goal initiated on 01/10/25, was the resident would be free of any discomfort or adverse side effects from pain or medication through the review date. The interventions, initiated 01/10/25, were staff was to administer pain medications as ordered by the physician and review frequently for pain medication effectiveness.</p> <p>Record review of Resident #3's January 2025e MAR reflected the physician's order for Lorazepam 1mg, 1 tablet to be given by mouth every 4 hours as needed for anxiety or agitation. The order start date was 01/11/25 and stop date was 01/15/25. Resident #3's eMAR reflected this medication was documented as administered to Resident #3 1 time as follows:</p> <p>01/13/25 at 10:00 am by LVN I.</p> <p>Record review of Resident #3's controlled drug receipt/record/disposition form for Lorazepam, dated 01/10/25 to 01/13/25, reflected 1 tablet of Lorazepam 1mg was administered to Resident #3 and not documented in the January 2025 eMAR for 9 of the 10 administrations as follows:</p> <p>1/10/25 at 8:00 pm by LVN N.</p> <p>1/11/25 at 1:30 am by LVN N.</p> <p>1/11/25 at 9:00 am by LVN B.</p> <p>1/11/25 at 5:00 pm by LVN B.</p> <p>1/11/25 at 10:00 pm by LVN J.</p> <p>1/12/25 at 2:00 am by LVN J.</p> <p>1/12/25 at 7:00 pm by LVN N.</p> <p>1/12/25 at 11:00 pm by LVN N.</p> <p>1/13/25 at 4:00 am by LVN N.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's January 2025 eMAR reflected the physician's order for ABH gel (Lorazepam 1mg, Diphenhydramine 25mg, Haloperidol 1mg) to be applied to the inner wrist every 4 hours as needed for agitation. The order start date was 01/11/25 and stop date was 01/15/25. Resident #3's eMAR reflected this medication was documented as administered to Resident #3, 1 of the 10 times that it was documented as administered on the controlled drug receipt/record/disposition form from 01/11/25 to 01/14/25.</p> <p>Record review of Resident #3's controlled drug receipt/record/disposition form for ABH gel reflected the ABH gel was administered to Resident #3 and documented in the January 2025 eMAR for 9 of the 10 administrations as follows:</p> <p>01/10/25 at 9:30 pm by LVN N.</p> <p>01/11/25 at 1:40 am by LVN N.</p> <p>01/11/25 at 2:00 pm by LVN B.</p> <p>01/11/25 at 11:00 pm by LVN J.</p> <p>01/12/25 at 8:00 pm by LVN N.</p> <p>01/13/25 at 1:00 am by LVN N.</p> <p>01/13/25 at 5:00 am by LVN N.</p> <p>01/13/25 at 10:00 pm by LVN F.</p> <p>01/14/25 at 2:00 am by LVN F.</p> <p>Record review of Resident #3's January 2025 eMAR reflected the physician's order for Tramadol 50mg, 1 tablet to be given by mouth every 6 hours as needed for pain. The order start date was 01/11/25 and stop date was 01/15/25. Resident #3's MAR reflected this medication had no documented administrations.</p> <p>Record review of Resident #3's controlled drug receipt/record/disposition form for Tramadol reflected 1 tablet of Tramadol 50mg was administered to Resident #3 and was not documented in the January 2025 MAR for 2 of the 2 administrations as follows:</p> <p>1/10/25 at 8:00 pm by LVN N.</p> <p>1/11/25 at 2:00 am by LVN N.</p> <p>2. Record review of Resident #4's admission record reflected a [AGE] year-old male who was admitted to the facility on [DATE] with an original admitted [DATE]. His diagnoses included a local infection of the skin and subcutaneous (below the skin) tissue, infection of the right leg amputation stump (the end part of healthy tissue that remains after the diseased or injured part was surgically removed), and phantom limb syndrome with pain (a condition in which a person experiences pain sensations in a limb or part of a limb [in this case his right leg] that was surgically removed).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #4's comprehensive care plan reflected a focused area, initiated on 11/15/24, of pain medication therapy (acetaminophen-codeine, tramadol) r/t bilateral (both sides) above the knee amputations. The goal initiated on 11/15/24, was the resident would be free of any discomfort or adverse side effects from pain or medication through the review date. The interventions, initiated 11/15/24, were staff were to administer pain medications as ordered by the physician and monitor/document for side effects and pain medication effectiveness.</p> <p>Record review of Resident #4's physician orders reflected an order for Acetaminophen-Codeine 300-30mg, 1 tablet to be given by mouth every 6 hours as needed for pain level over 4. The order start date was 12/13/24 and modified on 01/16/25 to add not to exceed 3 grams (of acetaminophen) in 24 hours.</p> <p>Record review of Resident #4's January and February 2025 eMARs reflected 1 tablet of Acetaminophen-Codeine 300-30mg was documented as administered to Resident #4 20 of the 54 times it was documented as administered on the controlled drug receipt/record/disposition form from 01/01/25 to 02/04/25.</p> <p>Record review of Resident #4's controlled drug receipt/record/disposition form for Acetaminophen-Codeine reflected 1 tablet of Acetaminophen-Codeine 300-30mg was administered to Resident #4 and not documented in the January or February 2025 MARs 30 of the 50 administrations as follows:</p> <p>01/01/25 at 8:00 am by LVN R.</p> <p>01/02/25 at 11:00 pm by LVN J.</p> <p>01/03/25 at 5:00 am by LVN J.</p> <p>01/03/25 at 10:00 am by LVN S.</p> <p>01/04/25 at 8:00 am by LVN S.</p> <p>01/04/25 at 6:00 pm by LVN R.</p> <p>01/05/25 at 12:00 am by LVN R.</p> <p>01/05/25 at 8:00 pm by LVN R.</p> <p>01/06/25 at 8:00 pm by LVN R.</p> <p>01/07/25 at 9:00 pm by LVN R.</p> <p>01/08/25 at 9:00 am by LVN S.</p> <p>01/08/25 at 8:00 pm by LVN Q.</p> <p>01/09/25 at 8:00 am by LVN S.</p> <p>01/10/25 at 8:00 pm by LVN J.</p> <p>01/12/25 at 6:00 pm by LVN J</p> <p><i>(continued on next page)</i></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>01/15/25 at 6:00 pm by LVN J.</p> <p>01/16/25 at 9:30 pm by LVN U.</p> <p>01/17/25 at 3:20 am by LVN Q.</p> <p>01/18/25 at 8:00 pm by LVN Q.</p> <p>01/20/25 at 8:00 pm by LVN U.</p> <p>01/24/25 at 8:00 pm by LVN B.</p> <p>01/25/25 at 9:00 pm by LVN J.</p> <p>01/26/25 at 1:00 am by LVN J.</p> <p>01/26/25 at 5:00 am by LVN J.</p> <p>01/26/25 at 7:00 pm by LVN R.</p> <p>01/28/25 at 1:24 pm by ADON D.</p> <p>01/29/25 at 1:07 pm by LVN P.</p> <p>01/30/25 at 1:45 am by LVN Q.</p> <p>01/30/25 at 3:42 pm by LVP P.</p> <p>01/31/25 at 4:42 pm by LVN P.</p> <p>02/03/25 at 6:00 pm by LVN J.</p> <p>02/04/25 at 12:00 am by LVN J.</p> <p>02/04/25 at 8:00 pm by LVN J.</p> <p>Record review of Resident #4's physician orders reflected an order for Tramadol 50m g, 1 tablet to be given by mouth every 6 hours as needed for pain level over 5. The order start date was 12/15/24.</p> <p>Record review of Resident #4's January 2025 eMAR reflected 1 tablet of Tramadol 50mg was documented as administered to Resident #4, 5 of the 7 times it was documented as administered on the controlled drug receipt/record/disposition form from 01/19/25 to 01/29/25.</p> <p>Record review of Resident #4's controlled drug receipt/record/disposition form for Tramadol reflected 1 tablet of Tramadol 50mg was administered to Resident #4 and not documented in the January 2025 [DATE] of the 7 administrations as follows:</p> <p>01/23/25 at 1:00pm by LVN P.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>01/28/25 at 7:45pm by LVN Q.</p> <p>3. Record review of Resident #5's admission record reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included schizophrenia (a disorder characterized by hallucinations- seeing or hearing things that aren't real, disorganized thinking, and disorganized speech) schizoaffective disorder (mental health condition characterized by symptoms of schizophrenia and symptoms of a mood disorder such as depression), depression (a common mental health condition characterized by persistent low mood, loss of interest or pleasure in activities, and other symptoms that interfere with daily functioning), and generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities).</p> <p>Record review of Resident #5's quarterly MDS reflected a BIMS score of 14, which indicated he was cognitively intact.</p> <p>Record review on of Resident #5's comprehensive care plan reflected a focused area initiated on 07/10/24 of the use of antianxiety medication r/t anxiety disorder. The goal initiated on 07/10/24 was the resident would be free from discomfort or adverse reactions r/t antianxiety therapy through the review date. The interventions initiated on 07/10/24 included staff was to administer antianxiety medications as ordered by the physician and monitor for side effects and effectiveness every shift. The care plan also reflected a focused area initiated on 06/24/24 of a mood problem r/t schizoaffective disorder, depression, and anxiety. The goal initiated on 06/24/24 was the resident would have improved mood state (no s/sx of depression, anxiety, or sadness) through the review date. The interventions initiated on 06/24/24 included staff was to administer medications as ordered and monitor/ document for side effects and effectiveness.</p> <p>Record review of Resident #5's physician orders reflected an order for Ativan 0.5mg, 1 tablet to be given by mouth every 8 hours as needed for anxiety. The order start date was 01/31/25.</p> <p>Record review of Resident #5's February 2025 eMAR reflected 1 tablet of Ativan 0.5mg was documented as administered to Resident #5, 5 of the 8 times it was documented as administered on the controlled drug receipt/record/disposition form from 02/02/25 to 02/05/25.</p> <p>Record review of Resident #5's controlled drug receipt/record/disposition form for Ativan reflected 1 tablet of Ativan 0.5mg was administered to Resident #5 and not documented in the February 2025 MAR, 3 of the 8 administrations as follows:</p> <p>02/03/25 at 5:03 pm by LVN V.</p> <p>02/04/25 at 8:00 pm by LVN J.</p> <p>02/05/25 at 4:00 am by LVN J.</p> <p>In an interview on 02/04/25 at 3:44 pm, LVN B stated LVN B stated anytime narcotics were administered it was supposed to be documented in the computer and on the narcotic log. LVN B stated he sometimes forgot to document it on the computer MAR. LVN B stated if it was not documented accurately, it could lead to a resident being over or under medicated. LVN B stated the last in-service on medication administration and documentation was last month and it was usually done about every 3 months.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 02/05/25 at 9:46 am, the DON stated when narcotic medications were administered the nurse was supposed to document it on the narcotic log as well as on the eMAR. The DON stated his expectation was nurses documented accurately and timely when medications were administered otherwise residents could receive their medications too early or too late which could lead to a resident having an uncontrolled medical issue related to the specific medication.</p> <p>In an interview on 02/05/25 at 11:02 am, ADON E stated her expectation was all nurses documented all information, not just medication administration, timely and accurately so that the residents received the care needed and the medications as prescribed. ADON E stated they had an in-service regarding medication administration, medication storage last month and in-services were done once every month or three months and as needed.</p> <p>In a telephone interview on 02/05/25 at 11:54 am, LVN F stated any time narcotic medications were given, it was to be documented in the narcotic log and in the eMAR, but she forgot to document it in the computer sometimes if she was busy.</p> <p>In an interview on 02/05/25 at 4:30 pm, LVN I stated when narcotics were administered, they were documented in the narcotic log and the eMAR. LVN I stated if it was not documented correctly she would get into trouble and it would possibly lead to a medication error such as a resident being over medicated or under medicated because a medication was given too soon or too late. LVN I stated the last in-service on medication administration, documentation, and narcotics was in January.</p> <p>In an interview on 02/05/25 at 5:51 pm, LVN J stated when a narcotic was administered, it was documented in the narcotic logbook and the eMAR. LVN J stated he sometimes forgot to document it in the eMAR which could lead to the resident being overmedicated and could result in a medication error, possible overdose, respiratory depression, hospitalization , or even death if the nurse after him gave an as needed narcotic or sedative medication and did not check the log first. LVN J stated the last in-service on medication administration and narcotics was a couple of weeks ago and they were in-serviced anytime a new nurse was hired or at least every 3 months.</p> <p>In interview on 02/06/25 at 9:55 am, LVN L verbalized the proper procedure for narcotic check and signed off at shift change. LVN L stated the last in-service on medication administration/ storage and narcotic checks/ documentation was in the evening of 02/05/25.</p> <p>In an interview on 02/06/25 at 11:15 am, LVN N stated when a narcotic was given, it was supposed to be written in the narcotic log and documented in the eMAR but when it was really busy, she would sometimes get sidetracked and not document it in the eMAR. LVN N stated she had never not logged it on the narcotic log. LVN N stated if a medication administration was not documented in the eMAR and another nurse gave the same medication again, it could cause a resident to be over medicated which could lead to increased side effects, hospitalization , etc . LVN N stated the last in-service on medication/narcotic administration/documentation was last month and were done at least quarterly.</p> <p>Record review of the facility's Administering Medications policy. dated April 2019. reflected in part:</p> <p>23. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  San Rafael Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3050 Sunnybrook Rd Corpus Christi, TX 78415	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>24. As required or indicated for a medication, the individual administering the medication records in the resident's medical record:</p> <ul style="list-style-type: none"> <li>a. the date and time the medication was administered .</li> <li>f. any results achieved and when those results were observed; and</li> <li>g. the signature and title of the person administering the drug.</li> </ul> <p>Record review of the facility's Documentation of Medication Administration policy, dated April 2007, reflected in part:</p> <p>Policy Statement</p> <p>The facility shall maintain a medication administration record to document all medications administered.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> <li>1. A Nurse or Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR).</li> <li>2. Administration of medication must be documented immediately after (never before) it is given.</li> <li>3. Documentation must include, at a minimum: <ul style="list-style-type: none"> <li>d. date and time of administration;</li> <li>f. signature and title of the person administering the medication; and</li> <li>g. resident response to the medication, if applicable (e.g., PRN, pain medication, etc.).</li> </ul> </li> </ol>