

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Signature Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 14655 Preston Rd Dallas, TX 75254	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46403</p> <p>Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional principles, for 2 of 4 medication carts (3rd floor) and 2 of 2 medication refrigerators (2nd and 3rd floor) reviewed for medication storage.</p> <p>1. The facility failed on 06/06/24 to ensure the 2nd floor medication refrigerator was free of discharged residents' narcotic medications and kept narcotic sheet record.</p> <p>2. The facility failed on 06/06/24 to ensure the 3rd floor medication cart and medical refrigerator was free of discharge residents' expired medication and discounted medications (medications that residents were no longer taking).</p> <p>These failures could affect all residents by placing them at risk of ingestion/exposure to medications not intended for them and risk of possible minimized potency from receiving expired medications.</p> <p>Findings include:</p> <p>Record review of Resident #1 face sheet revealed she had a planned discharge to home or other community on 06/03/24.</p> <p>Record review of Resident#2 face sheet revealed he had a planned discharge to home or other community on 05/24/24.</p> <p>Record review of Resident #3 face sheet revealed he had a planned discharge to home or other community on 09/09/21.</p> <p>Record review of narcotic book for Resident #2 revealed no narcotic sheet for Resident #2 Lorazepam 2mg/ml 30 ml bottle.</p> <p>Record review of narcotic book for Resident #3 revealed no narcotic sheet for Resident #3 Lorazepam 2mg/ml 30 ml bottle.</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
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident#5 Prescription orders revealed Novolin 70-30 Flex pen u-100 was started on 05/08/24 and discounted on 06/04/24.</p> <p>Observation on 06/06/24 at 10:28 AM of the medication room (2nd floor SNF side) with LVN S revealed (6) Lantus Solostar insulin pens for Resident #1.</p> <p>Observation on 06/06/24 at 10:30 AM of the medication room (2nd floor SNF side) with LVN S revealed (1) 30ML bottle of Lorazepam 2mg/ml for Resident #2.</p> <p>Observation on 06/06/24 at 10:31 AM of the medication room (2nd floor SNF side) with LVN S revealed (1) 30 ML bottle of Lorazepam 2mg/ml for Resident#3.</p> <p>Observation on 06/06/24 of the medication cart #1 (3rd floor) revealed Resident#4 had an open expired Insulin Lisp vial with expiration date of 05/03/24.</p> <p>Observation on 06/06/24 of the medication cart #2 (3rd floor) revealed Resident#5 had (2)70/30 Novolin pens on the medication cart that she was no longer taking.</p> <p>Observation on 06/06/24 of the refrigerator in the medication room revealed (6) 70/30 Novolin pens in a Ziploc bag and (3) 70/30 Novolin pens in a Ziploc bag that Resident#5 was no longer taking.</p> <p>Interview on 06/06/24 at 10:35 AM revealed no narcotic sheets for the 2 bottles of 30 ml Lorazepam 2mg/ml. LVN S revealed nursing staff were responsible for giving the medications of discharged residents to the ADON when the resident was leaving. LVN S revealed the medication would either go with the resident or be disposed of by the ADON and DON. The LVN S revealed narcotic medication could have been stolen.</p> <p>Interview on 06/06/24 at 11:30 AM with RN R revealed discharged medication and expired medication was supposed to be given to the ADON and DON to be disposed of.</p> <p>Interview on 06/06/24 at 11:45 AM RN E stated according to the manufacturer instructions the medication was no longer safe for residents to take after insulin pen or vial had been opened for 28 days. RN E stated the medication effectiveness was no longer useful. RN E stated medication left on the medication cart and refrigerator that belonged to a resident who no longer took could result in medication error. RN E revealed resident could get the wrong medication. RN E stated that medication that needed to be dispose of went into the locked black trash bin in the medication room. RN E stated insulin that needed to be disposed of goes in a hazard bag and then goes into the locked trashed bin.</p> <p>Interview on 06/06/24 at 12:00 PM AL Director/ADON (2nd floor SNF side) stated the DON and 2 nurses must sign off for discharged and expired medication. AL Director/ADON stated when residents are discharged the medication should have been pulled that same day. AL Director/ADON stated there was not a narcotic sheet for the 2 bottles of Lorazepam, and they could have stolen.</p> <p>Interview on 06/06/24 at 12:30PM with Resident#5 revealed she did not know what the name of her insulin.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 06/06/24 at 12:46 PM DON and ADON stated expired medication should go in the locked trash bin in the medication room. DON and ADON stated insulin would go in biohazard bags and put in the locked trash bin. DON and ADON revealed if resident were gone (hospitalized) for 1 day or more the medication is supposed to be pulled from the medication cart. DON and ADON stated the wrong dosage of medication could be given to the resident and cause an adverse reaction and cause a medication error. DON and ADON stated narcotic medication could disappear if it is not being accounted for.</p> <p>Record review of the facility policy: Controlled substances revised November 2022, reflected the following: 1. Control substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up 3. Nursing staff count controlled medication inventory at the end of each shift, using those records to reconcile the inventory count.7. Waste and / or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet .14. Accountability records for discontinued controlled substances are kept with unused supply until it is destroyed or disposed of as required by applicable law or regulations.</p> <p>Review of the facility's policy Administering Medications revised April 2010, reflected the following: 12. The expiration/beyond date on the medication label is checked .when opening a multi-dose container, the date opened is recorded on the container.</p>		