STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675850	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coastal Palms Nursing & Rehabilitation	221 Cedar Dr Portland, TX 78374

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 1 residents (Resident # 1) reviewed for significant medication errors, in that; The facility administered Resident #1's Clonidine outside of physician ordered parameters which resulted in Resident #1 being transferred to the hospital due to low blood pressure. This failure placed residents at risk for not receiving therapeutic dosages and placed them at risk for a decline in health. The noncompliance was identified as Past Non-Compliance. The facility had corrected the noncompliance before the investigation began. The findings included: Record review of Resident #1's face sheet dated 7/16/24 reflected an [AGE] year-old-female with an original admitted [DATE] and a BIMS of 6. Diagnoses included heart failure, chronic kidney disease, dementia (general decline and cognitive abilities that affects a person's ability to perform everyday activities), and chronic obstructive pulmonary disease (inflammatory lung disease that causes obstructed air flow from the lungs). Record review of Resident #1's physician orders dated 1/13/24 stated: Clonidine hcl oral tablet 0.1 mg to be given by mouth two times a day for HTN if systolic blood pressure is greater than 160 and diastolic blood pressure is greater than 100. Resident #1's medication for Clonidine hcl oral tablet 0.1 mg was discontinued on 5/8/24. Record review of Resident #1's medication administration record dated from 1/13/24 to 5/6/24 reflected medication administration of Clonidine was given outside of parameters a total of 166 times by various staff members on various shifts. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 4/2/23 documented Resident #1 had heart disease, high blood pressure, and was at risk for associated cardiac complications such as chest pain, SOB, fatigue, dizziness, poor endurance/activity intolerance and edema. Related to heart failure, hyperlipidemia/High Cholesterol, and hypertension. Interventions included: Administer medications as ordered by physician. Record review of the medication administration record for Resident #1's Clonodine administration dated 5/8/24 reflected a blood pressure of 142/87 when Resident #1's Clonodine was last administered prior to hospitalization . Record review of facility's investigation summary stated on 5/6/24 at 12:00am Resident #1 was noted by staff to appear different. LVN A stated Resident #1 was able to answer questions but not as appropriately as usual. LVN A did not state any other signs and symptoms Resident #1 was displaying. Resident #1 was assessed by LVN A and Resident #1 had a blood pressure of 84/45. Resident #1 The MD ordered Resident #1 to be sent to the hospital for further evaluation. 911 was initiated by staff and Resident #1 was transferred to a local hospital. During an observation/interview on 7/15/24 at 1:00pm Resident #1 was in bed. Resident #1 stated she had been in the hospital recently but stated it was for her stomach and nothing was wrong. Resident #1 stated her blood pressure was usually normal and had not been low lately and could not recall going to the hospital for having low blood pressure. In an interview on 7/16/24 at 10:18am the ADM stated Resident #1 went to the hospital due to something going on with her blood pressure. The ADM stated that all nurses were in-serviced on medication administration and following parameters. The ADM stated the MD was notified upon residents return and Resident #1's order for Clonidine was discontinued. The ADM stated an audit of all high blood pressure medications being given in the facility were audited and that it was discovered Resident #1's medication was being given outside of MD ordered parameters. The facility administration staff began an investigation, and a 4 step plan was implemented immediately. The ADM stated it was important to follow all doctor orders and blood pressure medication parameters as it could have had an adverse affect on residents. The ADM stated the DON was usually in charge of verifying orders and medication admistration was administered as ordered but the DON at the time was no longer employed with the facility. Attempted to contact former DON a total of 3 times beginning on 7/17/24 with no answer. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview on 7/16/24 at 10:26pm the Regional Nurse Consultant stated the DON at the time informed her that Resident #1 was going to be sent to the hospital due to low blood pressure around the beginning of May 2024. The Regional Nurse Consultant stated a family member of Resident #1 spoke to staff about concerns with Resident #'1 blood pressure medications after Resident #1 had been hospitalized . The Regional Nurse Consultant stated when staff were reviewing Resident #1's chart, the order for Clonidine was transcribed in a confusing way. The Regional Nurse Consultant stated Resident #1's Clonidine order read; to give twice a day but only if Resident #1's blood pressure was greater than 160/100 but was interpreted as a scheduled medication instead of PRN. The Regional Nurse Consultant stated that was when they realized Resident #1's medication was being given outside of parameters by some nurses. The Regional Nurse Consultant stated Resident #1's blood pressure was always stable. The Regional Nurse Consultant stated the IDT was the team that reviewed medications and were reviewed upon admission and whenever there was an alert on the system for that medication. The Regional Nurse Consultant stated when medications are held, or not given, the system flags those medication for review. The Regional Nurse Consultant stated the system only displayed that specific medication administration time the medication was held and would not show all administrations for that medication. The Regional Nurse Consultant stated that was why the medication errors were missed when Resident #1 was given Clonidine outside of the parameters. In a phone interview on 7/16/24 at 3:46pm, Resident #1's MD stated the medication Clonidine should not be given to Resident #1 if it was not within the parameters as ordered. The Physician stated Resident #1 could have experience light headedness due to a low blood pressure. The physician stated the medication Clonidine should not have had a long-lasting affect and the medication has since been discontinued for Resident #1. In a phone interview on 7/25/24 at 10:16am the Pharmacist stated he would speak with this surveyor with a staff member present and requested the ADM be present. Noted ADM and ADON present during phone interview. The Pharmacist stated Clonidine was a medication given to control high blood pressure and was usually given PRN but could be given scheduled. The Pharmacist stated if Clonidine was ordered to be given at scheduled times, it should have a parameter to when to hold or administer the medication. The Pharmacist stated if the medication Clonidine was given outside of parameters Resident #1 could experience lightheadedness, possible blurred vision but it would have depended on Resident #1's baseline. The Pharmacist stated with a blood pressure of 84/42 it could have been an emergent situation, but would be based on Resident #1's baseline blood pressure. Separate interviews with LVN A, LVN B, LVN C, and LVN D beginning on 7/15/24 revealed they were administering Resident #1's Clonidine medication outside of parameters but stated since the medication was ordered twice a day, they were not clicking on Resident #1's medication order to expand the full order to reveal the parameters and thought the medication was scheduled. LVN A, LVN B, LVN C, and LVN D stated they had one on one training on medication administration and following MD parameters on high blood pressure medications. Through record review and interview of the facility's action plan, prior to entrance on 7/13/24, the facility conducted the following: -5/8/24 Resident #3's physician and RP were notified of medication error. -5/8/24 ADHOC and QAPI completed with Medical Director and a 4-step response plan implemented. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-5/8/24 One to one re-education initiated with specific nurses identified working during the time of Clonidine medication administration on following parameters for blood pressure medications. -5/8/24 Initiated re-education for all nurses/new staff related to medication administration, following parameters for blood pressure medications, 5 rights of medication administration, medication reconciliation upon resident's admissions or when receiving a new blood pressure medication ordered by doctor included parameters to know when to administer or hold medications. -5/8/24 Audit of residents in the facility taking blood pressure medications initiated by DON/Designee to ensure blood pressure parameters were being followed and any adverse effects noted. -3 residents were audited randomly 3 times a week for 8 weeks to confirm medication parameters were being followed correctly in MAR. Record review of facility residents audit binder reviewed and initiated on 5/8/24 through 7/14/24 with no concerns identified. -5/8/24 Initiated re-education with staff regarding abuse, neglect, and resident rights. Record review of Medication Administration Policy dated 3/2019 stated: Compliance Guidelines: Resident medications are administered in an accurate, safe, timely, and sanitary manner. 2. Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route. 6. Administer medications as ordered by the physician. Routine medication shall be administered according to the established medication administration schedule for the community.