

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675887	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2025
NAME OF PROVIDER OR SUPPLIER  St. Joseph Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  2333 Manor Dr Bryan, TX 77802	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of three residents reviewed for pharmacy services.</p> <p>The facility failed to prevent a diversion of Resident #1's Modafinil 100 MG tablet, 30 tablets received from the pharmacy on 06/15/2025 and reported missing on 06/16/2025.</p> <p>LVN A and LVN B failed to conduct shift change narcotics medication count on the morning of 06/16/2025.</p> <p>These failures could place residents at risk for medication error and delay therapy.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, printed 06/26/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included sleep apnea (a common sleep disorder where breathing repeatedly stops and starts during sleep), unspecified, obstructive sleep apnea (a common sleep disorder where breathing repeatedly stops and starts during sleep due to a blockage in the upper airway), morbid obesity (a serious health condition characterized by a body mass index (BMI) of 40 or greater, or a BMI of 35 or greater with obesity-related health complications) due to excessive calories, epilepsy (is a brain condition that causes seizures) unspecified.</p> <p>Record review of Resident #1's physician order reflected an order, dated 06/13/2025 for Modafinil Oral Tablet 100 MG (Modafinil) Give 1 tablet by mouth one time a day for sleepiness related to sleep apnea, unspecified (G47.30) -D/C Date- 06/16/2025 09:54.</p> <p>Record review of Resident #1's comprehensive care plan initiated 06/14/25, reflected the resident had bladder incontinence related to cognitive mobility limitations, which affects my ability to stay dry and manage toileting needs independently.</p> <p>Record review of Resident #1's comprehensive MDS assessment, dated 06/20/2025, Section C (Cognitive Patterns) reflected a BIMS score of 15, which indicated no impaired cognition.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's medication administration record for June 2025, reflected Modafinil Oral Tablet 100 MG (Modafinil) was never administered after admission.</p> <p>Record review of Resident #1's clinical records dated 06/16/2025 reflected Resident #1's Modafinil 100 MG was discontinued due to Resident not previously being on the medication.</p> <p>Record review of the Provider Investigation Report, dated 06/16/2025, reflected, On 6/15/2025 at 11:38 PM, the pharmacy delivered Modafinil 100mg (quantity 30) to the facility. The receiving nurse handed it to the nurse assigned to the resident. who reported placing it in the narcotic storage box with the pharmacy's count sheet, however, during the 6:00 AM shift change, no narcotic count was performed, and it was discovered that both the medication and the count sheet were missing.</p> <p>Record review of the facility's pharmacy requisition sheet, dated 06/15/2025, reflected the pharmacy delivered 30 pills of Modafinil Oral Tablet 100 MG for Resident #1 and it was signed by LVN D.</p> <p>During an interview on 06/26/2025 at 2:03 PM, LVN B stated she worked the 6:00 AM to 6:00 PM shift on 06/16/2025 with Resident #1. LVN B stated during shift change at 6AM on 06/16/2025, she and LVN A did not count narcotics. LVN B stated LVN A left the cart keys for the hall-4 medication aide narcotics cart and hall-4 nurse's cart in the narcotics count book like LVN A always did. LVN B stated she counted the narcotics on both carts by herself and all the medications on the carts matched the count sheets. LVN B stated she did not see Resident #1's Modafinil 100 MG tablet on Saturday, 06/14/2025, she texted the NP for the medication script, and the NP stated she would send the script to the pharmacy. LVN B stated on Sunday morning, 06/15/2025, Resident #1's Modafinil 100 MG tablet was still not delivered, and she notified the NP who was in the facility at the time and the NP stated she called the medication in to the pharmacy but would call it in again. LVN B stated on Monday morning, 06/16/2025, she noticed Resident #1's pain medication was delivered but her Modafinil 100 MG tablet was still not delivered so she called the pharmacy. LVN B stated she was told by the Pharmacy staff Resident #1's modafinil 100 MG tablet was delivered on the night of 06/15/2025 and was signed for by LVN D, the 6:00 PM to 6:00 AM nurse from hall 3. LVN B stated LVN D was called but there was no response. LVN B stated she initiated a search for Resident #1's Modafinil 100 MG tablet on all carts in the facility, all medication rooms in the facility, and the medication was not found. LVN B stated she checked the pharmacy requisition form and noted Resident #1's Modafinil 100 MG tablet was delivered on 06/15/2025. LVN B stated she notified the ADON, the ADON notified the DON, and they searched all carts in the facility again and the medication was still not found. LVN B stated when they finally got hold of LVN D, LVN D stated she gave Resident #1's MODAFINIL 100 MG TABLET, 30 pills delivered by the pharmacy on the night of 06/15/2025 to LVN A. LVN B stated she was asked by the DON to write a statement and was suspended for 1 day for not counting narcotics at change of shift. LVN B stated she was in-serviced by the DON on narcotics count at the change of shift before turning over the keys, 2 nurses were to sign for narcotics being delivered by the pharmacy, all narcotics were removed from the medication aide's cart to the nurse's cart. LVN B stated she knew she was supposed to count the narcotics at shift change but LVN A did not want to count. LVN B stated she did not notify the DON or the ADON of she LVN A not counting narcotics at change of shift. LVN B stated it was important to count narcotics at change of shift to prevent drug diversion and ensure narcotics were accurate.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/26/2025 at 3:14 PM, LVN A stated she worked the night of 06/15/2025 on the 6:00 PM to 6:00 AM shift into the morning of 06/16/2025. LVN A stated LVN D gave her Resident #1's medications delivered by pharmacy on the night of 06/15/2025, which included Resident #1's Modafinil 100 MG tablet. LVN A stated on the morning of 06/16/2025, she and LVN B did not count the medication carts for hall-4 (nurse's and medication aide carts). LVN A stated she put Resident #1's Modafinil 100 MG tablet 30 pills in the medication aide medication cart on hall-4. LVN A stated, this particular nurse [LVN B] refused to count, she [LVN B] has a bad attitude, bad about counting. When she [LVN B] works behind me, I count by myself and leave the keys in the narcotic book. She [LVN B] was not going to count. She [LVN B] made it clear that she [LVN B] doesn't count. The process was, at change of shift, you get report, you count with the incoming or off going shift and we sign the narcotic book. The medication aide come in at about 7:30- 8AM, the nurses count both carts. It was the nurse's and the medication aide cart that we didn't count. For the nurses cart keys, I left it in the narcotic book and the medication aide keys I give to the nurse [LVN B]. I know the process that I am supposed to count with someone. We are supposed to count to make sure the counts are correct. LVN A stated she was called to the facility on 6/16/2025, she wrote a statement and spoke with the ADON and DON. LVN A stated she was suspended and was still suspended pending drug test results which was done on 06/20/2025. LVN A stated she was in-serviced on 06/20/2025 on not leaving the medication cart keys on the book on the cart and mandatory counting with the other nurse.</p> <p>Attempted interview on 06/26/2025 at 03:27 PM with LVN D were unsuccessful. Attempts were made to contact LVN D, unable to reach via phone, unable to leave a message due to mailbox being full.</p> <p>Attempted interview on 06/26/2025 at 03:30 PM with CNA C were unsuccessful. Attempt were made to contact CNA C, staff who witnessed LVN D giving Resident #1's medications to LVN A, there was no response, left a voice message, no call back.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/26/2025 at 3:41 PM, the ADON stated she was made aware by LVN B Resident #1's Modafinil 100 MG tablet was missing. The ADON stated LVN B went to give Resident #1's medication and Resident #1's Modafinil 100 MG tablet was not available and prompted LVN B to call the pharmacy and was told the medication was delivered. The ADON stated LVN B notified her, and she called the DON and notified the DON. The ADON stated she was instructed by the DON to check all the medication carts in the facility and all the medication rooms. The ADON stated she was helped by the Wound Care Nurse, they both looked together to make sure they were not missing. The ADON stated they did not find Resident #1's Modafinil 100 MG tablet. The ADON stated she notified the DON Resident #1's Modafinil 100 MG tablet was not in the building. The ADON stated she called LVN A and LVN A did not answer the call. The ADON stated she sent a text to LVN A and LVN A said she specifically remembered the medication in questioned, and she [LVN A] put the medication in the medication aide medication cart on hall-4. The ADON stated LVN A stated she remembered receiving the medication from LVN D. The ADON stated the DON called LVN A and had LVN A coming to the facility on [DATE]. The ADON stated when LVN A got to the facility on 06/16/2025, she stayed with LVN A. The ADON stated when the DON got to the facility, the DON checked the unit 4 cart because LVN A stated she put Resident #1's Modafinil 100 MG tablet 30 pills on the cart. The ADON stated LVN A and LVN B was kept in the facility while the police were being notified. The ADON stated the Police officer spoke with LVN A and LVN B to get their statements. The ADON stated the Police Officer stated the medication in question was not with LVN A and LVN B and there was no way to know who took the medication. The ADON stated both LVN A and LVN B were suspended pending the investigation. The ADON stated all nurses and medication aides were in-serviced on counting medications at the change of shift, it was changed to where all narcotics were placed on the nurse's carts. The ADON stated LVN B was back at work and LVN A was not yet back due to a pending drug test result. The ADON stated she and the DON started doing random cart checks as 06/23/2025. The ADON stated the process was at change of shift the nurse gave the oncoming nurse report, counted both carts on the hall, nurses, and medication aide cart because the medication aides were scheduled to work from 7:00 AM, some at 8:00 AM.</p> <p>During an interview on 06/26/2025 at 1:56 PM, the DON stated she was made aware by the ADON Resident #1's Modafinil 100 MG tablet was missing. The DON stated the ADON stated they were checking to make sure the medication was not on a different medication cart. The DON stated when she got to the facility, she called the pharmacy to ensure the medication was delivered and it was confirmed, and she checked the medication cart and did not see Resident #1's Modafinil 100 MG tablet. The DON stated she notified the Police, she suspended LVN A and LVN B pending investigation, staff wrote statements, the MD and RP were made aware. The DON stated LVN A was drug tested on [DATE] at about 11:58 AM and the result was still pending. The DON stated, based on the investigation, they did not know who took Resident #1's Modafinil 100 MG tablet 30 pills. The DON stated the procedure was at change of shift, the nurses and the medication aides counted narcotics with the incoming/off going shift and signed the narcotics book to ensure all narcotics were accounted for. The DON stated it was the expectation the staff counted when receiving or relieving duties. The DON stated it was not okay for LVN A to just leave the keys in the narcotic book. The DON stated she did not know LVN A and LVN B had a situation where they were not counting narcotics at shift change. The DON stated the narcotic count was part of the facility's policy and she expected the staff to follow the facility's policy. The DON stated Resident #1's Modafinil 100 MG tablet was for excessive sleepiness, to keep Resident #1 alert. The DON stated after the investigation, it was noted Resident #1 had not taken the medication since 2023, the prescription had not been refilled. The DON stated Resident #1's Modafinil 100 MG tablet was never found in the facility. The DON stated she and the ADON audited the medication carts randomly, 2 nurses had to sign when narcotics were being delivered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's in-services, date 06/16/2025, reflected:</p> <p>In-Service for Controlled Substance Administration and Accountability.</p> <p>Record review of the facility's in-services, dated 06/18/2025, reflected:</p> <p>Medication delivery: Charge nurses for each unit must meet and take responsibility and sign for the medication for their residents. Narcotics must be placed in the nurse's lock box on the nurse's cart; Count sheet must be placed in binder with your signature as well as a witnessed nurse signature.</p> <p>Record review of LVN A and LVN B 's personnel files reflected they were reprimanded on 06/16/2025 due to not counting controlled medications on medication aide and nurse's medication cart.</p> <p>Record review of the facility's Controlled Substance audit reflected:</p> <p>Controlled Substance Audit-- was conducted on 06/23/2025 on halls 2, 3 and 4.</p> <p>Record review of the facility's policy titled Abuse, Neglect, and Exploitation, dated 2025, reflected:</p> <p>Policy:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation _ and</p> <p>misappropriation of resident property.</p> <p>Misappropriation of Resident's Property_ means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident s belongings or money without the resident's consent.</p> <p>Record review of the facility's, undated, policy titled Controlled Substance Administration &amp; Accountability, reflected:</p> <p>Policy:</p> <p>It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure .</p> <p>g.</p> <p>In all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record.</p> <p>h.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration.</p> <p>The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy.</p> <p>J.</p> <p>The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify:</p> <p>i.</p> <p>Controlled substances that are destroyed are appropriately documented; and</p> <p>ii.</p> <p>Medications removed from either the automated dispensing system or medication cart/cabinet have a documented physician order .</p> <p>3.</p> <p>Ordering and Receiving Controlled Substances:</p> <p>a.</p> <p>The pharmacy maintains the supply of controlled substances in automated dispensing systems.</p> <p>b.</p> <p>For patient care areas which do not utilize automated dispensing systems, daily orders for stock narcotics are filled out by the charge nurse according to the following procedure:</p> <p>i.</p> <p>The amount on hand is checked against the amount used daily from the documentation records.</p> <p>ii.</p> <p>The designated order form is completed and sent to the appropriate pharmacy making sure it contains the following:</p> <p>a)</p> <p>Unit/Wing ordering the medication.</p> <p>b)</p> <p>(continued on next page)</p>		

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