

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Benbrook Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 McKinley St Benbrook, TX 76126	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152</p> <p>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 nine residents reviewed for pharmacy services.</p> <p>The facility failed to order Resident #1's routine Oxycontin timely to prevent three missed doses, 5:00 AM and 5:00 PM on 09/26/2024 and 5:00 AM on 09/27/2024.</p> <p>This failure placed residents at risk of worsening and/or exacerbation of their pain and medical conditions.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet dated 09/27/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Diagnoses included: Chronic obstructive pulmonary disease (lung disease that causes restrictive airflow), anxiety disorder due to unknow psychological condition (a mental health condition that causes fear and dread), major depressive disorder (mental health condition impacting how a person feels, thinks and acts), bipolar disorder, current episode manic severe psychotic features (can include episodes of hallucinations, delusions, disordered thinking, and lack of awareness of reality), Paroxysmal Arterial fibrillation (irregular heartbeat), and old myocardial infarction (previous heart attack).</p> <p>Record review of Resident #1's Initial MDS Assessment, dated 08/26/2024, reflected a BIMS score of 14 which indicated he was cognitively intact. He was independent for self-care and indoor mobility. He used a walker to ambulate. His pain assessment indicated persistent and occasional pain.</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 Care Plan dated 09/19/2024, reflected, Problem: [Resident #1] has a behavior problem (Throwing items, yelling) r/t poor impulse control. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet [Resident #1's] needs. Problem: [Resident #1] is verbally aggressive to staff regarding pain medications r/t Ineffective coping skills, Poor impulse control. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Assess resident's understanding of the situation. Allow time for [Resident #1] to express self and feelings towards the situation. Psychiatric/Psychogeriatric consult as indicated. [Resident #1's] triggers for verbal aggression are based around pain medication administration and seeking other narcotics. [Resident #1] behaviors is [sic] de-escalated by receiving pain medication. Problem: [Resident #1] is on pain medication therapy (NORCO, Oxycontin) r/t chronic pain. Intervention: Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. Monitor/document/report PRN adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus [itchy skin], respiratory distress/decreased respirations, sedation, urinary retention. Review for pain medication efficacy. assess whether pain intensity acceptable to resident, no treatment regimen or change in regimen required; Controlled adequately by therapeutic regimen no treatment regimen or change in regimen required but continue to monitor closely; Controlled when therapeutic regimen followed, but not always followed as ordered; Therapeutic regimen followed, but pain control not adequate, changes required.</p> <p>Record review of Resident #1's MAR reflected on 09/26/2024 Oxycontin scheduled at 5:00 AM and 5:00 PM was checked as administered although interviews revealed it was not given. Oxycontin scheduled on 09/27/2024 was marked as hold. PRN Hydrocodone 10-325 mg was given.</p> <p>Record review of Resident #1's medication orders revealed, Hydrocodone-acetaminophen 10-325 mg by mouth every 6 hours as needed for pain, initiated 09/04/2024, with no stop date. Oxycontin extended release 12-hour 30 mg, administered by mouth two times a day for back pain, initiated 09/03/2024, with no end date.</p> <p>Record review of Resident #1's progress note dated 09/26/2024 at 4:50 AM reflected, [Resident #1] requested Hydrocodone at this time and noted as effective, pain level 0 at 6:06 AM.</p> <p>Record review of Resident #1's progress note dated 09/26/2024 at 12:30 PM reflected, after giving hydrocodone for pain management. I f/u with [Resident #1] who had been up and walking around and went out for cigarettes. [Resident #1] was not in distress and up in the dining room with other residents for lunch while [sic] taking and enjoying his lunch with other residents. Hydro working effectively.</p> <p>Record review of Resident #1's progress note dated 09/26/2024 at 1:46 PM reflected, [Resident #1] screamed at night shift nurse bcus his oxy was not here but explained that it was called in an on its way. [Resident #1] was giving PRN hydrocodone at 4:50 AM for pain. [Resident #1] screamed and pointed the middle finger at other employee bcus she stated he did not have to talk so ugly to staff. [Resident #1] continue to call 911 to come and pick him up to go out for oxy. EMT arrived and took him out to [hospital]. [Resident #1] returned to the facility with no new orders and was giving two norco at 8:15 AM at the ER. On report from hospital, they stated that [Resident #1] should be good for remainder of the day.</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>In an interview on 09/27/2024 at 9:48 AM, LVN A stated Resident #1 was on scheduled Oxycontin two times daily at 5:00 AM and 5:00 PM. She said he also had PRN Hydrocodone ordered every 6 hours. She said she called the pharmacy on 09/25/2024 to order Resident #1's Oxycontin and the pharmacy told her they needed a new script from the doctor. She said she informed Pain NP B on the same day when she was in the facility, that Resident #1's Oxycontin needed to be refilled and NP B said she would send the script. She said Resident #1 did not have any Oxycontin left for administration on 09/26/2024. She said on 09/26/2024 the medication was not in the facility, and she followed up with the pharmacy again. She said she was told they did not have the script from the doctor. She said she checked the ekit (emergency medication kit) and the medication was not there. She said she did not contact the MD because he would refer her to the pain doctor. LVN A said she spoke to NP C on 09/26/2024 who said she would send the script. LVN A said when she followed up with the pharmacy today (09/27/2024), they told her they received the script at 4 AM. She said Resident #1 missed both scheduled doses of Oxycontin on 09/26/2024 and the dose scheduled for 09/27/2024 at 5:00 AM. She said Resident #1 did call EMS because he wanted to go to the hospital for anxiety due to missing his scheduled pain medication. LVN A said when he returned from the hospital a short time later, they instructed that they provided two Hydrocodone and Resident #1 should not require additional pain medication for at least 6 hours. LVN A stated the medications should be ordered when there was a week's supply of doses remaining. She said the pain NPs were in the facility twice a week and always asked if renewed scripts were needed. She said she did not know when Resident #1's Oxycontin was left to deplete before reordering.</p> <p>In an interview on 09/27/2024 at 10:21 AM, NP C said she was notified on 09/26/2024 at 4:26 PM that Resident #1's Oxycontin needed to be refilled. She said she sent the script to the pharmacy last night (09/26/2024). She said she and NP A were in the facility twice a week and typically were on top of refills. She said facility staff also had access to her 24/7 via phone. She said Resident #1's Oxycontin was long-acting pain medication, and the PRN Hydrocodone was for short-term pain management. She said since Resident #1 received Hydrocodone at the facility and then again at the hospital on 06/26/2024 and reported a 0 level for pain, the missed doses of Oxycontin did not seem to have any adverse effect.</p> <p>In a telephone interview on 09/27/2024 at 10:30 AM, NP B said LVN A did tell her on 09/25/2024 Resident #1's Oxycontin needed to be refilled. NP B said she forgot and did not send the script to the pharmacy. She said Resident #1's pain seemed to be managed with the PRN Hydrocodone but if it had not, she would expect the facility to send him to the hospital.</p> <p>In an interview on 09/27/2024 at 11:26 AM, MA D said when medications get low, she notified the nurses, and they would reorder. She stated Resident #1 did not have any Oxycodone on 09/26/2024 but he did get PRN Hydrocodone at 4:50 AM and did not indicate any pain. She said he did go to the hospital later in the morning on 09/26/24 and was sent back to the facility a short time later.</p> <p>In an interview on 09/27/2024 at 11:50 AM, the Administrator stated he expected the facility nurses and the pain management team to communicate any resident needs. He said the facility should not have run out of Resident #1's Oxycontin which caused him to miss both doses on 09/26/2024. He said this could have caused Resident #1 increased pain.</p> <p>(continued on next page)</p>		

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