

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Gracy Woods Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12021 Metric Blvd Austin, TX 78758	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 4 residents reviewed (Resident #2) reviewed for care plan, in that:</p> <p>The care plan for Residents #2 failed to address any of the resident's need, because Resident #2 did not have a care plan.</p> <p>These failures could affect the resident by placing him at risk for not receiving care and services to meet his needs.</p> <p>Findings included:</p> <p>Review of Resident #1's initial MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE]. Further review of the sections revealed:</p> <p>C - Cognitive Patterns reflected he had a BIMS of 12 (suggesting moderately impaired cognition) with disorganized thinking,</p> <p>Section H - Bladder and Bowel reflected he had an Ostomy (a life-saving procedure that allows bodily waste to pass through a surgically created stoma on the abdomen into a prosthetic known as a pouch or ostomy bag on the outside of the body or internal surgically created pouch for continent diversion surgeries) and always incontinent.</p> <p>Section I - Active Diagnoses reflected he had a stroke</p> <p>Section I - Active Diagnoses reflected he had hypertension</p> <p>Section I - Active Diagnoses reflected he had a Seizure Disorder or Epilepsy, malnutrition, depression, and an anxiety disorder</p> <p>Section J - Health Conditions reflected he had one injure, a skin tear since his admission</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Section K - Swallowing/Nutritional Status reflected he had loss of liquids/solids from mouth when eating or drinking, coughing, or choking during meals or when swallowing medications, and complaints of difficulty or pain with swallowing and required mechanically altered diet - require change in texture of food or liquids (e.g. , pureed food, thickened liquids)</p> <p>Section M - Skin Conditions revealed he was at risk of developing pressure ulcers/injuries, Section M - Skin Conditions revealed he requires pressure reducing device for bed,</p> <p>Section N - Medications revealed he was on antidepressant and an anticoagulant (blood thinner)</p> <p>Section V - Care Area Assessment revealed care areas triggered for cognitive loss/dementia, urinary Incontinence and Indwelling catheter, psychosocial well-being, falls and nutritional status, pressure ulcer and psychotropic drug use.</p> <p>Review of Resident #1's care plan on 04/26/2024 reflected that it was blank.</p> <p>Interview on 04/22/2024 with the Administrator at 2:15 pm revealed the care plan helped provide guidance for the resident's needs and improves resident care. It was important to the resident's safety. The care plan should include safety needs, resident transfer needs, behavior and emotional needs and any type of service that deals with quality of care. The care plan should be updated at least quarterly and if there was a change of condition. If the care plan was incomplete, the staff would not have the guidance it needs for important issues with the resident and to prevent any issues with the resident.</p> <p>Interview on 04/22/2024 with the DON at 4:32 pm revealed care plans are important because they identify health care issues that require monitoring and should include anything that the facility needs for taking care of the resident. She revealed that the care plan should paint a picture of the patient needs. If the facility does not have a care plan, it can affect the resident's safety. The care plan is for making sure that the needs of the resident are met.</p> <p>Care Planning - Interdisciplinary Team</p> <p>Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. A comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). 2. The care plan is based on the residence comprehensive assessment and is developed by the care planning/interdisciplinary team which includes but is not necessarily limited to the following personnel: <ol style="list-style-type: none"> a. The residents attending physician; b. the registered nurse who has responsibility for the resident; <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708</p> <p>Based on observation, interview, and record review the facility failed to ensure that pain management was provided to a resident who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 resident (Resident #1) reviewed for pain, in that:</p> <p>The facility failed to:</p> <p>Provide pain medication ordered for resident with a diagnosis of malignant cancer who suffered from chronic pain.</p> <p>An Immediate Jeopardy (IJ) was identified on 04/23/2024. The IJ template was provided to the facility on [DATE] at 5:57 PM. While the IJ was removed on 04/26/2024, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p> <p>This failure could place residents at risk for prolonged and unnecessary pain and suffering, decreased mobility, decreased quality of life, and decreased quality of care.</p> <p>Findings included:</p> <p>Review of Resident #1s undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and most current re-admission 04/21/2024 diagnoses including malignant neoplasm of peripheral nerves and autonomic nervous system (rare cancers that start in the lining of the nerves), abrasion of lower back and pelvis, adrenocortical insufficiency (occurs when the adrenal glands don't make enough of the hormone cortisol) and pain.</p> <p>Review of Resident #1 's MDS dated [DATE] reflected a BIMS of 15 indicating no cognitive impairment. Further review revealed over the last 5 days she had pain or hurting, experienced pain frequently, and pain had made it difficult for her to sleep occasionally. Verbal descriptor scale of pain over the last 5 days revealed the intensity of her pain has been severe. Over the last 5 days the resident had received a scheduled pain medication.</p> <p>Review of Resident #1's care plan dated 08/22/2023 revealed category of special care monitor for the presence of pain/intolerance during self-care activities. Category dated 08/22/2023 ADLs Functional Status/Rehabilitation Potential Monitor/record/report for presence of pain/intolerance during transfers.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Handwritten circles were around the initials of the staff member and a blank space in a date and time box reflected methadone schedule II 10 mg. was not given to the resident, 25 times because it was not available and therefore not administered.</p> <p>02/09/2024 7:00 am</p> <p>02/12/2024 3:00 pm</p> <p>02/14/2024 11:00 pm</p> <p>02/16/2024 3:00 pm</p> <p>02/20/2024 7:00 am and 11:00 pm</p> <p>02/21/2024 3:00 pm and 11:00 pm</p> <p>02/22/2023 11:00 pm</p> <p>02/23/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>02/24/024 11:00 pm</p> <p>02/25/2024 11:00 pm</p> <p>02/26/2024 7:00 am and 11:00 pm</p> <p>02/27/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>02/28/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>02/29/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>Handwritten circles were around the initials of the staff member which reflected hydromorphone schedule II table 4 mg. was not given to the resident, 16 times because it was not available and therefore not administered.</p> <p>02/17/2024 - 02/20/2024</p> <p>Handwritten notes on reverse side of Resident #1's of the MAR revealed hydromorphone reflected, 02/17/2024 hydromorphone on order (nurse notified).</p> <p>Handwritten circles around the initials of the staff member who was responsible to administer methadone schedule II 5 mg. tab. was not given to the resident, 20 times because it was not available and therefore not administered.</p> <p>03/01/2024 11:00 am and 7:00 pm</p> <p>03/02/2024 11:00 am and 7:00 pm</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>03/03/2024 - 03/10/2024 11:00 and 7:00 pm</p> <p>Record review of Resident #1's March 2024 paper MAR beginning 02/08/2024 revealed the following:</p> <p>Handwritten circles around the initials of the staff member who was responsible to administer methadone schedule II 10 mg. reflected that the ordered medication was not given to the resident, 17 times because it was not available and therefore not administered.</p> <p>03/01/2024 - 03/02/2024</p> <p>03/03/2024 7:00 am</p> <p>03/03/2024 3:00 pm</p> <p>03/04/2024 - 03/06/2024</p> <p>Handwritten note on the reverse side of the methadone schedule II 10 mg. MAR reflected, date illegible, MD Notified.</p> <p>Handwritten circles around the initials of the staff member who was responsible to administer hydromorphone schedule II tablet 4 mg. reflected that the ordered medication was not given to the resident, 38 times because it was not available and therefore not administered.</p> <p>03/02/2024 1:00 pm</p> <p>03/03/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/04/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/05/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/06/2024 1:00 pm, 7:00 am and 1:00 pm</p> <p>03/16/2024 7:00 pm</p> <p>03/17/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/18/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/19/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/20/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/21/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/22/2024 1:00 am</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Handwritten notes of reverse side of Resident #1's hydromorphone schedule II tablet 4 mg schedule II MAR reflected the following handwritten notes :</p> <p>03/02/2024 awaiting pharmacy for methadone 5 mg., methadone 10 mg., and hydromorphone II,</p> <p>03/16/2024 residents medication not given awaiting pharmacy see nurses notes,</p> <p>03/17/2024 resident medication not given hydromorphone 4 tabs see nurses notes, and</p> <p>03/19/2024 am hydromorphone 4 mg (4 tabs) not available will notify NP in AM.</p> <p>Record review of Resident #1's April 2024 paper MAR beginning 02/08/2024 revealed the following:</p> <p>Review of Resident #1's paper medication administration record for April 2024 order reflect tab. oral twice a day 02/08/2023 - open ended. The handwritten circles around the initials of the staff member who was responsible to administer methadone schedule II 5 mg. was not given to the resident, 4 times because it was not available and therefore not administered.</p> <p>04/08/2024 11:00 am and 7:00 pm</p> <p>04/09/2024 11:00 am and 7:00 pm</p> <p>Handwritten circles around the initials of the staff member who was responsible to administer methadone schedule II 10 mg. was not given to the resident, 10 times because it was not available and therefore not administered.</p> <p>04/06/2024 11:00 pm</p> <p>04/07/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>04/08/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>04/09/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>Handwritten circles around the initials of the staff member who was responsible to administer hydromorphone schedule II tablet 4 mg. was not given to the resident, 18 times because it was not available and therefore not administered.</p> <p>04/05/2024 1:00 am, 7:00 am, and 1:00 pm</p> <p>04/06/2024 1:00 am, 7:00 am, and 1:00 pm</p> <p>04/07/2024 1:00 am, 7:00 am, and 1:00 pm, and 7:00 pm</p> <p>04/08/2024 1:00 am, 7:00 am, and 1:00 pm, and 7:00 pm</p> <p>04/09/2024 1:00 am, 7:00 am, and 1:00 pm, and 7:00 pm</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with Resident #1 on 04/22/2024 at 11:27 am revealed she was feeling better since her return from the hospital, and she was getting her pain medications. She said there have been several times she had not received her pain medications while living at the facility and it was because they have run out of them. She said occasionally they will give her Tylenol #3 when her pain medications are not available, but it does not help very much. She said she was always in pain at a constant level, on a pain level of a 6 - 7 all the time and she told the facility she was in pain. Prior to her last hospital admission on 04/09/2024 she said she had not been given pain medications for a long time but was unsure of how long she had not been receiving them. She said she told them the pain was in her legs and that this was a different and terrible pain. She said her legs hurt very badly. The day she was admitted to the hospital she had a shower, and the pain was terrible, and she was crying from the pain and LVN A saw her crying. She called EMS herself to be taken to the hospital.</p> <p>Interview with LVN A on 04/24/2024 at 2:55 pm revealed Resident #1 sometimes did not get her pain medications because they could not get the prescription for the order filled. At times they would give her Tylenol #3, but it was not effective, and the hydromorphone helped her more. LVN A revealed Resident #1 was in pain every day, because of her condition, cancer. LVN A revealed Resident #1 was crying and Resident #1 told LVN A she said she was having pain and Resident #1 told LVN A the pain was too much. LVN A called the NP for Tylenol #3 on 04/09/2024 and it was administered to Resident #1, but it did not help, and you could see from Resident #1's facial expressions and Resident #1's crying that the Tylenol #3 did not help. LVN A said she had never seen her crying that way. LVN A revealed she was in pain every day and it was important for her to give Resident #1 her pain medications because she was in pain, and she was a cancer patient.</p> <p>Interview with the DON on 04/24/2024 at 1:14 pm and 04/26/2024 at 3:09 pm revealed Resident #1 had a diagnosis for pain because she had cancer and Resident #1 had orders for prescription pain medications and the NP and MD took care of Resident #1's pain medication and that the facility had nothing to do with Resident #1's insurance, it was with the doctors. The DON said Resident #1 was in pain all the time, but they could not get her prescription filled, so there was nothing to do. The DON revealed it was not okay for Resident #1 to even have gone a day without her pain medication and the DON understood how high Resident #1's pain level was. The DON revealed she was not aware that Resident #1 was crying because of her pain. The staff did not bring it to her attention that she was crying except the day she went to the hospital. The orders from the doctor should have been filled. Resident #1 suffered from chronic pain and the facility was aware that she suffered from chronic pain. The DON was responsible for making sure medications are ordered and that there is a process in place to make sure residents receive the medication.</p> <p>Interview with the Administrator on 04/26/2024 ADM at 2:50 pm revealed he was aware that there was a struggle and an issue with her Resident #1 her pain medication and it was his understanding that the pain was addressed. He thought it was addressed because they contacted the MD, and another medication was ordered that resolved the pain and that did not happen. If a resident goes without pain medication the resident could have severe pain and suffering. He revealed Resident #1's needs were not being meet and he knew she was in pain but did not know she was crying. He revealed he was aware Resident #1 called the EMS because of her pain and was surprised to hear that Resident #1 called the EMS as opposed to a staff member. He revealed the nursing staff and facility did not meet her needs.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Facility Policy Administering Medications dated 04/2019 revealed the Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescribed orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:</p> <p>a. Enhancing optimal therapeutic effect of the medication .</p> <p>If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 04/23/2024 at 5:57 pm. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 04/23/2024 at 5:57 pm.</p> <p>The following POR was accepted on 04/25/2024 11:01 am. and included:</p> <p>On 4/19/2024 an abbreviated survey was initiated at [facility]. On 4/23/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety.</p> <p>The notification of Immediate Threat states as follows:</p> <p>IJ Component: F697 Pain Management</p> <p>Facility failed to issue prescription pain medications Hydromorphone and Methadone as ordered for [AGE] year-old female resident.</p> <p>Immediate Actions:</p> <ol style="list-style-type: none"> 1. Resident returned to facility on 4-21-24. Upon return, pain assessment was completed by a licensed nurse and resident denied pain and was documented on 4-21-2024. 2. Resident returned to facility on 4-21-2024 with a new order to discontinue hydromorphone and methadone and start morphine. Morphine medication was filled and dispensed 4-21-2024. A licensed nurse assured medication filled and assesses pain every shift. Completed 4-21-2024. <p>Facility Plan to ensure compliance:</p> <ol style="list-style-type: none"> 1. DON/designee will re-educate pain management with emphasis on the assessing recognizing, identifying, and addressing the underlying cause of the pain as well as assuring medication is in the facility. The Regional Nurse Consultant and [NAME] President of Operations provided in-service to DON and Administrator. Staff that are on leave from the facility, as well as newly hired staff in the future will be given the pain management education by the same individuals noted above before starting their next shift. This facility does not employ the use of agency personnel. Initiated on 4/23/2024. Completed 4/24/2024. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Gracy Woods Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12021 Metric Blvd Austin, TX 78758	

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>2. Licensed nurse to perform pain assessments on all current residents and address any pain that is identified. Completed 4/23/2024</p> <p>3. The Regional Consultant Nurse provided in-service to DON, ADON, and Administrator. DON/designee to re-educate licensed nurses on pain assessment, to include verbal and non-verbal signs of pain and reporting pain to provider (NP/MD). Licensed nurses will be in-serviced as needed thereafter. Licensed nurses will be in-serviced as needed thereafter. Staff that are on leave from the facility, as well as newly hired staff in the future will be given the pain education by the same individuals noted above before starting their next shift. This facility does not employ the use of agency personnel. Licensed nurses will be in-serviced as needed thereafter. Staff that are on leave from the facility, as well as newly hired staff in the future will be given the pain competency check off by the same individuals noted above before starting their next shift. This facility does not employ the use of agency personnel. Initiated on 4/23/2024. Completed 4/23/2024</p> <p>4. The Medical Director was notified by Administrator on 4/23/2024 at 9:00 pm on the immediate jeopardy citation.</p> <p>5. An Ad-hoc QAPI meeting was held on 4/23/2024 by the interdisciplinary team to discuss the immediate jeopardies and review the plan of removal.</p> <p>Monitoring:</p> <p>1. DON/designee will perform medication reconciliation twice a week and ongoing to ensure pain medication is available for residents receiving pain medications.</p> <p>2. DON/designee will review the 24-hour report Monday through Friday, and RN designate will review the 24 hour report every Saturday and Sunday, to ensure residents pain is being documented and controlled, MD is being notified, and changes of condition are documented and interventions are initiated for pain management.</p> <p>3. The above will be reviewed in the monthly facility QA meeting for no less than 60 days or until the Administrator determines substantial compliance has been achieved and maintained.</p> <p>On 04/26/2024 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by:</p> <p>Interview on 04/26/2024 at 11:26 am with RN A revealed she worked the 6:00 am - 2:00 pm shift and she was in-serviced on pain management and pain assessment. When she goes to a patient room, she is going to ask them if they are in pain and check their vitals and see if heart is elevated if they are in pain. She revealed that if you look at a patient, you can tell if they are pain. If the patient is in pain, ask where the pain is if they know what was causing it and when it started.</p> <p>Interview on 04/26/2024 at 11:38 am with RN B revealed he worked either 8:00 am - 5:00 pm or 6:00 am - 2:00 pm was in-serviced in pain assessment and management. He revealed all residents should be assessed for pain. Pain depends on the individual and was based on their diagnosis and if they have chronic pain. He revealed pain was individual for every person and should be prioritized as much as anything else if not more. If a resident cannot verbally tell you, they are in pain then he needs to see if the resident was grimacing or moaning. Staff need to look at resident's pain history.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 04/26/2024 at 12:11 pm with LVN B revealed she attended an in-service about pain assessment in detail. She revealed there are two ways to assess a resident's pain one was to ask them and the second is to look at them. If they cannot tell them look at their diagnoses and assess residents completely if they can't respond. Pain is different for everyone. It can depend on their tolerance and their diagnoses.</p> <p>Interview on 04/26/2024 at 12:46 pm with LVN A revealed she works the 2:00 pm - 10:00 pm shift and the 10:00 pm - 6:00 am shifts and was PRN and she attended an in-service about pain. She said she received a copy of a document that discussed pain assessment and management and discussed the procedures of identify pain with a resident.</p> <p>Interview on 04/26/2024 at 12:49 pm with LVN C revealed she was PRN she has worked all there of the facility shifts. She attended an in-service regarding pain management. She learned about different types of pain and that residents may have different symptoms that may indicate that they need something different. She revealed nurses need to evaluate the individual needs and differences of each of the residents when evaluating for pain.</p> <p>Interview on 04/26/2024 at 1:17 pm with LVN D revealed he works 10:00 pm - 6:00 am and was in-serviced about pain management. If a resident can speak, you can ask them and they can tell you about their pain and a resident cannot speak you need to see if they are grimacing or frowning to assess their level of pain.</p> <p>Interview on 04/26/2024 at 2:08 pm with LVN revealed he works the 10:00 pm - 6:00 am shift and she was in-serviced about pain management. To assess a resident for pain she can look at the face of the resident for a grimace, ask if they are hurting, ask the severity of the pain and assess for all symptoms. She revealed nurses need to check their full body for their position and vitals. She revealed she does a head-to-toe assessment.</p> <p>Interview on 04/26/2024 at 2:26 pm with RN C revealed he works either 6:00 am - 2:00 pm or 2:00 pm - 10:00 pm and she was in-serviced on assessing pain. To assess pain, you look at the patient and ask how they are doing and if they say they are in pain ask questions about the pain including where did it start and how long has it lasted. If someone was nonverbal you must look at their facial expressions. The resident might be moaning or crying or be depressed. You can touch them and know if they are in pain or not.</p> <p>Interview on 04/26/2024 at 2:36 pm with LVN F revealed he works 2:00 am - 10:00 pm and he attended some in-services about medication. He received an in-service about pain assessment and pain management, and they discussed how to assess the resident's pain for both verbal and nonverbal residents and that pain is different and unique to all residents.</p> <p>Interview on 04/26/2024 at 2: 05 pm with the Administrator revealed he received in-services on 4/23/24 from the RVPO about on pain management and pain and ensuring resident pain control needs are met by facility staff. He learned about symptoms of pain and making sure he understands the nurse's role for assessing for pain and to make sure the medical staff address resident pain immediately.</p> <p>Interview with the DON at 3:09 pm revealed she was in serviced by RNC about the maintenance of resident pain control with the understanding of pain control management and communication with her nursing staff.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Reviewed the 04/23/2024 in-service given by RNC to the DON regarding pain assessment and management.</p> <p>Reviewed the 04/23/2024 in-service given by the RVPO to the Administrator regarding pain assessment and management.</p> <p>Reviewed the 04/23/2024 in-service given to the nursing staff by the DON regarding pain assessment and management.</p> <p>Review of staff list and in service trainings reflected 80% of staff in serviced.</p> <p>The Administrator was informed the Immediate Jeopardy was removed on 04/26/2024 at 3:52 pm. While the IJ was removed on 04/26/2024, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p>

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</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** 46708</p> <p>Based on observation, 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 1 of 4 residents reviewed (Resident #1) for pharmacy services.</p> <p>The facility failed to:</p> <p>Provide pain medication ordered, for three consecutive months for different time frames, for resident with a diagnosis of malignant cancer who suffered from chronic pain.</p> <p>An Immediate Jeopardy (IJ) was identified on 04/23/2024. The IJ template was provided to the facility on [DATE] at 5:57 PM. While the IJ was removed on 04/26/2024, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p> <p>A second IJ was identified on 05/15/2024 at 2:54 pm in the same area of non-compliance. The Administrator and the DON were notified. The Administrator was provided with an additional IJ template on 05/15/2024 at 2:54 pm.</p> <p>This failure could place residents at risk of not receiving the therapeutic benefits of medications which could lead to advanced injury, increased pain, and diminished quality of life.</p> <p>Findings included:</p> <p>Review of Resident #1s undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and most current re-admission 04/21/2024 diagnoses including malignant neoplasm of peripheral nerves and autonomic nervous system (rare cancers that start in the lining of the nerves), abrasion of lower back and pelvis, adrenocortical insufficiency (occurs when the adrenal glands don't make enough of the hormone cortisol) and pain.</p> <p>Review of Resident #1 's MDS dated [DATE] reflected a BIMS of 15 indicating no cognitive impairment.</p> <p>Review of Resident #1's Quarterly MDS dated [DATE] reflected, over the last 5 days she has had pain or hurting, over the last 5 days she experienced pain frequently, over the last 5 days pain had made it her for her to sleep occasionally. Verbal descriptor scale of pain over the last 5 days revealed the intensity of her pain has been severe. Over the last 5 days the resident had received a scheduled pain medication.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #1's care plan dated 08/22/2023 revealed category of special care monitor for the presence of pain/intolerance during self-care activities. Category dated 08/22/2023 ADLs Functional Status/Rehabilitation Potential Monitor/record/report for presence of pain/intolerance during transfers.</p> <p>Review of hospital records dated 04/09/2023 until discharge of Resident #1 to the facility on [DATE] reflected patient endorsed worsening lower left extremity pain and swelling for the last couple of weeks. She lived at a skilled nursing facility, and they ran out of her pain medication 2-3 weeks ago and she presented to the ED for uncontrolled lower left extremity pain and leg wound. She had a history of malignant neoplasm of peripheral nerves of thorax and malignant peripheral nerve sheath tumor of chest (a type of cancer that can occur in various locations of your body). Patient's cancer was locally advanced and not curable. As a result of the cancer, she experienced chronic pain for which she was on chronic opiates (including methadone). Hospital records indicate they initially thought her uncontrolled pain on presentation was due to her cancer, but X-rays revealed her femur was broken in several places.</p> <p>Review of Resident #1's paper chart medication orders reflected methadone schedule II 5 mg. amount to administer: 1 tab; oral twice a day pain unspecified 02/02/2024 open ended.</p> <p>Review of Resident #1's paper chart medication orders reflected methadone schedule II 10 mg. amount to administer: 3 tablets; oral every 8 hours pain, unspecified, 02/08/2023 - open ended.</p> <p>Review of Resident #1's paper chart medication order reflected hydromorphone schedule II tablet 4 mg. amount to administer; 4 tabs, oral every 6 hours hold for sedation pain, unspecified, 02/08/2024 - open ended.</p> <p>In an interview on 04/22/2024 at 12:26 pm the DON revealed that medication administration documentation is completed in the paper chart for residents. If a medication is not given, the person who is responsible for administering the medication drew a circle around their initials indicating that the medication was not administered to the resident. DON further stated a note was written on the back of the paper medication administration record, or sometimes both a circle and a note was written on the back of the paper medication administration indicating on the paper medication record that a resident's medication was not given. Additionally, if there was a blank in the space that should indicate the time and date a medication was scheduled to be given, the medication was not given. The DON said that if R#1 was not given her pain medication, it was because the medication was not available to give to her.</p> <p>Review of handwritten notes on reverse side of Resident #1's paper medication admission record for February 2024 for Resident #1's order for methadone schedule II 10 mg. amount to administer: 3 tablets; oral every 8 hours pain, unspecified, 02/08/2023 - open ended reflected the pain medications were not available to administer to Resident #1.</p> <p>02/20/2024 3:00 pm Methadone 10 mg. - not available</p> <p>02/21/2024 3:00 pm Methadone 10 mg. - not available</p> <p>02/22/2024 3:00 pm Methadone 10 mg. - not available</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>02/25/2024 3:00 pm Methadone 10 mg. - not available</p> <p>02/26/2023 3:00 pm Methadone 10 mg. - not available</p> <p>Review of Resident #1's paper medication administration record for February 2024 beginning 02/08/2024 reflect methadone schedule II 10 mg. amount to administer: 3 tablets; oral every 8 hours pain, unspecified, 02/08/2023 - open ended. The handwritten circles around the initials of the staff member who was responsible to administer the medication and a blank space in a date and time box reflected that the ordered medication was not given to the resident 25 times because it was not available and therefore not administered.</p> <p>02/09/2024 7:00 am</p> <p>02/12/2024 3:00 pm</p> <p>02/14/2024 11:00 pm</p> <p>02/16/2024 3:00 pm</p> <p>02/20/2024 7:00 am and 11:00 pm</p> <p>02/21/2024 3:00 pm and 11:00 pm</p> <p>02/22/2023 11:00 pm</p> <p>02/23/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>02/24/2024 11:00 pm</p> <p>02/25/2024 11:00 pm</p> <p>02/26/2024 7:00 am and 11:00 pm</p> <p>02/27/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>02/28/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>02/29/2024 7:00 am, 3:00 pm, and 11:00 pm</p> <p>Review of Resident #1's paper medication administration record for February 2024 beginning 02/08/2024 reflected hydromorphone schedule II table 4 mg. amount to administer 4 tabs. oral every 6 hours hold for sedation pain unspecified 02/08/2024 - open ended. The handwritten circles around the initials of the staff member who was responsible to administer the medication reflected that the ordered medication was not given to the resident 16 times because it was not available and therefore not administered.</p> <p>02/17/2024 - 02/20/2024</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the reverse side of Resident #1's paper medication administration record for February 2024 for hydromorphone reflected, 02/17/2024 hydromorphone on order (nurse notified).</p> <p>Review of Resident #1's paper medication administration record for March 2024 order beginning 02/08/2024 reflect methadone schedule II 5 mg. tab. oral twice a day 02/08/2023 - open ended. The handwritten circles around the initials of the staff member who was responsible to administer the medication reflected that the ordered medication was not given to the resident 20 times because it was not available and therefore not administered.</p> <p>03/01/2024 11:00 am and 7:00 pm</p> <p>03/02/2024 11:00 am and 7:00 pm</p> <p>03/03/2024 - 03/10/2024 11:00 and 7:00 pm</p> <p>Review of Resident #1's paper administration medication for March 2024 order beginning 02/08/2024 reflected methadone schedule II 10 mg. amount to administer: 3 tablets; oral every 8 hours pain, unspecified, 02/08/2023 - open ended. The handwritten circles around the initials of the staff member who was responsible to administer the medication reflected that the ordered medication was not given to the resident 17 times because it was not available and therefore not administered.</p> <p>03/01/2024 - 03/02/2024</p> <p>03/03/2024 7:00 am</p> <p>03/03/2024 3:00 pm</p> <p>03/04/2024 - 03/06/2024</p> <p>Review of reverse side of Resident #1's paper medication administration record for March 2024 for methadone schedule II 10 mg. reflected, date illegible, MD Notified.</p> <p>Review of Resident #1's paper medication administration record for March 2024 for order beginning 02/08/2024 reflected hydromorphone schedule II tablet 4 mg. amount to administer: 4 tabs; oral every 6 hours hold for sedation pain unspecified 02/08/24 - open ended. The handwritten circles around the initials of the staff member who was responsible to administer the medication reflected that the ordered medication was not given to the resident 38 times because it was not available and therefore not administered.</p> <p>03/02/2024 1:00 pm</p> <p>03/03/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/04/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/05/2024 1:00 pm, 7:00 am, 1:00 pm, and 7:00 pm</p> <p>03/06/2024 1:00 pm, 7:00 am and 1:00 pm</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #1's paper medication administration record for April 2024 for order beginning 02/08/2024 reflected hydromorphone schedule II tablet 4 mg. amount to administer: 4 tabs; oral every 6 hours hold for sedation pain unspecified 02/08/24 - open ended. The handwritten circles around the initials of the staff member who was responsible to administer the medication reflected that the ordered medication was not given to the resident 18 times because it was not available and therefore not administered.</p> <p>04/05/2024 1:00 am, 7:00 am, and 1:00 pm</p> <p>04/06/2024 1:00 am, 7:00 am, and 1:00 pm</p> <p>04/07/2024 1:00 am, 7:00 am, and 1:00 pm, and 7:00 pm</p> <p>04/08/2024 1:00 am, 7:00 am, and 1:00 pm, and 7:00 pm</p> <p>04/09/2024 1:00 am, 7:00 am, and 1:00 pm, and 7:00 pm</p> <p>Interview with Resident #1 on 04/22/2024 at 11:27 am revealed she was feeling better since her return from the hospital, and she is getting her pain medications. She said that there have been several times she has not received her pain medications while living at the facility and it is because they have run out of them. She said occasionally they will give her Tylenol #3 when her pain medications are not available, but it does not help very much. She said she is always in pain at a constant level, on a pain level of a 6/10 - 7/10 all the time and she told the facility she was in pain. Prior to her last hospital admission on 04/09/2024 she said she had not been given pain medications for a long time but was unsure of how long she had not been receiving them. She said she told them that the pain was in her legs and that this was a different and terrible pain. She said her legs hurt very badly. The day she was admitted to the hospital she had a shower, and the pain was terrible, and she was crying from the pain and LVN A saw her crying. She called EMS herself to be taken to the hospital.</p> <p>Interview with LVN A on 04/24/2024 at 2:55 pm revealed Resident #1 sometimes did not get her pain medications because they could not get the prescription for the order filled. At times they would give her Tylenol #3, but it was not effective, and the hydromorphone helped her more. LVN A revealed Resident #1 was in pain every day, because of her condition, cancer. LVN A revealed Resident #1 was crying and Resident #1 told LVN A she had pain and Resident #1 told LVN A the pain is too much. LVN A called the NP for Tylenol #3 on 04/09/2024 (the day Resident #1 went to the hospital) and it was administered to Resident #1, but it did not help, and you could see from Resident #1's facial expressions and Resident #1's crying that the Tylenol #3 did not help. LVN A said she had never seen her crying that way. LVN A revealed she was in pain every day and it was important for her to give Resident #1 her pain medications because she was in pain, and she is a cancer patient.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Gracy Woods Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12021 Metric Blvd Austin, TX 78758	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with the DON on 04/24/2024 at 1:14 pm and 04/26/2024 at 3:09 pm revealed Resident #1 had a diagnosis for pain because she had cancer and Resident #1 had orders for prescription pain medications and the NP and MD took care of Resident #1's pain medication and that the facility had nothing to do with Resident #1's insurance, it was with the doctors. The DON said Resident #1 was in pain all the time, but the pharmacy could not get Resident #1's prescription filled because of insurance and paperwork delays, so there was nothing to do. The DON said that because Resident #1's medication was Schedule II controlled narcotics, they did not have them in the e-kit. The DON revealed it was not okay for Resident #1 to have gone even one day without her pain medication and the DON understood how high Resident #1's pain level was. The DON revealed she was not aware that Resident #1 was crying because of her pain. The staff did not bring it to her attention that she was crying except the day she went to the hospital. The orders from the doctor should have been filled. Resident #1 suffered from chronic pain and the facility was aware that she suffered from chronic pain. The DON is responsible for making sure medications are ordered and that there is a process in place to make sure residents receive the medication.</p> <p>Interview with the Administrator on 04/26/2024 ADM at 2:50 pm revealed he was aware that there was a struggle and an issue with obtaining Resident #1's pain medication and it was his understanding that her pain was addressed. He thought it was addressed because they contacted the MD, and another medication was ordered that resolved the pain and that did not happen. If a resident goes without pain medication the resident could have severe pain and suffering. He revealed Resident #1's needs were not being met and he knew she was in pain but did not know she was crying. He revealed he was aware Resident #1 called the EMS because of her pain and was surprised to hear that Resident #1 called the EMS as opposed to a staff member. He revealed the nursing staff and facility did not meet her needs.</p> <p>Facility Policy Administering Medications dated 04/2019 revealed the Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescribed orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:</p> <ul style="list-style-type: none"> a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions; and c. Honoring resident choices and preferences, consistent with his or her care plan. <p>If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 04/23/2024 at 5:57 pm. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 04/23/2024 at 5:57 pm.</p> <p>The following POR was accepted on 04/25/2024 11:01 am.</p> <p>PLAN OF REMOVAL</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Gracy Woods Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12021 Metric Blvd Austin, TX 78758	
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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 4/19/2024 an abbreviated survey was initiated at [NAME] Woods 1 Nursing Center. On 4/23/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety.</p> <p>The notification of Immediate Threat states as follows:</p> <p>IJ Component: F 755 Pharmaceutical services</p> <p>Facility failed to issue prescription pain medications Hydromorphone and Methadone as ordered for [AGE] year-old female resident.</p> <p>Immediate Actions:</p> <ol style="list-style-type: none"> 1. Resident returned to facility from the hospital on 4-21-24. Upon return, pain assessment was completed by licensed nurse, resident denied pain and was documented on 4-21-2024. 2. Resident returned to facility on 4-21-2024 with new order to discontinue hydromorphone and methadone and start morphine. Morphine medication was filled and dispensed 4-21-2024. A licensed nurse assured medication filled and assesses pain every shift. Completed 4-21-2024 <p>Facility Plan to ensure compliance:</p> <ol style="list-style-type: none"> 1. Licensed nurse to perform pain assessments on all current residents and address any pain that is identified. Completed 4/23/2024 2. DON/designee to re-educate licensed nurses in the process for unavailable medications and medications refusal to include steps to follow when medications are unavailable or refused by the resident. The Regional Nurse Consultant and [NAME] President of Operations provided in-service to DON and administrator. Staff that are on leave from the facility, as well as newly hired staff in the future will be given the pain medication education by the same individuals noted above before starting their next shift. This facility does not employ the use of agency personnel. Initiated on 4/23/2024. Completed 4/23/2024 3. DON/designee to re-educate licensed nurses on contacting physician for alternative pain medication to include obtaining a new order for an available pain medication from the E kit (facility's emergency medication kit). DON/designee to re-educate certified medication aides to notify licensed nurse when medication is not available. The Regional Nurse Consultant and [NAME] President of Operations provided in-service to DON and administrator. Staff that are on leave from the facility, as well as newly hired staff in the future will be given the pain medication education by the same individuals noted above before starting their next shift. This facility does not employ the use of agency personnel. Initiated on 4/23/2024. Completed 4/23/2024 4. The Medical Director was notified by Administrator on 4/23/2024 at 9:00 pm on the immediate jeopardy citation. 5. An Ad-hoc QAPI meeting was held on 4/23/2024 by the interdisciplinary team to discuss the immediate jeopardies and review the plan of removal. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 04/26/2024 at 1:29 pm with CMA D revealed he works 2:00 pm - 10:00 pm shift and was in-serviced on ordering medications specific to pain management medications. CMAs are supposed to let the charge nurse know when they are down to a 7-day supply of medications. At day 7 they will re-order or let the ADON or charge nurse reorder medications. If the facility is out of a medication he needs to get with the supervisor and the charge nurse to see if they can get it from the e-kit and he will inform the DON that the medication was not available. If the resident refuses a medication, let the nurse know.</p> <p>Interview on 04/26/2024 at 2:01 pm with CMA E revealed she works the 2:00 pm - 10:00 pm shift and she was in-serviced about ordering medications. If you are out of medications, you do not circle it. You notify the nurse, and she will get it from the e-kit. If you are out of a medication, you report it to the nurse and DON. At the point that a resident has only 7 days left of a medication, inform the nurse so she can request it. If the resident is complete out of a medication, the DON needs to be informed. If a resident tells you they do not want a medication, if they refuse it, let the nurse know.</p> <p>Interview on 04/26/2024 at 11:26 am with RN A revealed she worked the 6:00 am - 2:00 pm shift and she was in-serviced on the process for unavailable medications and how to order them and when to go to the e-kit. She will let the DON know if there are any problems with ordering medication or a resident does not have a medication. She has been educated what to do if a resident refuses a medication.</p> <p>Interview on 04/26/2024 at 11:38 am with RN B revealed he works either 8:00 am - 5:00 pm or 6:00 am - 2:00 pm was in-serviced in making sure that the residents have all their prescribed medication, when and how to order them and when to use the e-kit. She will inform the DON if there are any problems with resident medications. She will make a note in the resident's record if they refuse medication.</p> <p>Interview on 04/26/2024 at 12:11 pm with LVN B revealed she attended an in-service about the correct way to order medications and let the DON know if there are any medication issues and to put a note in the residents record if they refuse a medication. Use the e-kit to get medication if you can if and you can't make sure to notify the DON.</p> <p>Interview on 04/26/2024 at 12:46 pm with LVN A revealed she works the 2:00 pm - 10:00 pm shift and the 10:00 pm - 6:00 am shifts and is PRN and she attended an in-service making sure residents have their medications and how to make sure they have them. Use the e-kit and if the medication is not available, let the DON know immediately.</p> <p>Interview on 04/26/2024 at 12:49 pm with LVN C revealed she is PRN she has worked all three of the facility shifts. She attended an in-service regarding ordering medications and making sure the resident has the necessary medications. It is good to use the e-kit and let the DON know if there are any medications issues. Put a note in the resident record if they refuse to take one of their medications.</p> <p>Interview on 04/26/2024 at 1:17 pm with LVN D revealed he works 10:00 pm - 6:00 am and was in-serviced about getting resident medications to make sure beforehand there is not a problem. Use the e-kit and if any issues, let the DON know.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 04/26/2024 at 2:08 pm with LVN revealed he works the 10:00 pm - 6:00 am shift and she was in-serviced about obtaining the correct medications for a resident. It is important to let the DON know about any medications that are not available to the Resident and to use the e-kit and order medications before they run out.</p> <p>Interview on 04/26/2024 at 2:26 pm with RN C revealed he works either 6:00 am - 2:00 pm or 2:00 pm - 10:00 pm and she was in-serviced on getting resident medications ordered and how and when to use the e-kit and to write it in the resident chart if they refuse medications.</p> <p>Interview on 04/26/2024 at 2:36 pm with LVN F revealed he works 2:00 am - 10:00 pm and he attended some in-services about medications. He was told to let the DON know if there are not medications for the resident in the facility and to try and use the e-kit if something is missing.</p> <p>Interview on 04/26/2024 at 2: 05 pm with the Administrator revealed he received in-services on 4/23/24 from the RVPO about on pain management and pain and ensuring resident pain control needs are met by facility staff. He learned about symptoms of pain and making sure he understands the nurse's role for assessing for pain and to make sure the medical staff address resident pain immediately.</p> <p>Interview with the DON at 3:09 pm revealed she was in serviced by RNC about the maintenance of resident pain control with the understanding of pain control management and communication with her nursing staff.</p> <p>Reviewed the 04/23/2024 in-service given by RNC to the DON regarding pain assessment and management.</p> <p>Reviewed the 04/23/2024 in-service given by the RVPO to the Administrator regarding pain assessment and management.</p> <p>Reviewed the 04/23/2024 in-service given to the nursing staff by the DON regarding pain assessment and management.</p> <p>Reviewed Resident #1's pain assessment dated [DATE] completed by a licensed nurse.</p> <p>Interview and observation on 04/26/2024 at 2:50 pm of Resident #1 revealed she was out of bed, in her wheelchair, out of her room, visiting another resident and she said her pain was better and she was now taking morphine.</p> <p>Reviewed new order dated 04/21/2024 to discontinue hydromorphone and methadone and start morphine.</p> <p>Reviewed 04/23/2034 pain assessments performed by a licensed nurse on all current residents.</p> <p>Reviewed email dated 04/23/2024 from the Administrator notifying the Medical Director of the immediate jeopardy citation.</p> <p>Reviewed the Ad-hoc QAPI document that reflected a meeting was held on 4/23/2024 by the interdisciplinary team to discuss the immediate jeopardies and review the plan of removal.</p> <p>Review of staff list and in service trainings reflected 80% of staff in serviced.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Administrator was informed the Immediate Jeopardy was removed on 04/26/2024 at 3:52 pm. While the IJ was removed on 04/26/2024, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p> <p>Per administrative review, the investigation was reopened on 05/10/2024. A second IJ was identified and a new IJ template was provided to the facility on [DATE] at 2:54 PM.</p> <p>This was determined to be an additional Immediate Jeopardy (IJ) on 05/15/2024 at 2:54 pm in the same area of non-compliance. The Administrator and the DON were notified. The Administrator was provided with an additional IJ template on 05/15/2024 at 2:54 pm. An additional POR was required by the facility.</p> <p>The Facility failed to:</p> <p>Follow their facility policies and procedures and administer medication, pazopanib (chemotherapy medication), in accordance with Resident #1's prescribed orders who had a diagnosis of malignant terminal cancer. Resident #1 was never administered the medication, subsequently missing 24 doses.</p> <p>Review of the hospital discharge records dated 04/21/2024 reflected Resident #1 was prescribed pazopanib (chemotherapy medication) 200 mg. + 600mg oral once a day.</p> <p>Review of Resident #1's paper chart medication order reflected pazopanib (chemotherapy medication) 200 mg. + 600 mg. oral once a day.</p> <p>Review of Daily Skilled Nurse's Note (undated) reflected nurse spoke with the oncology office regarding the medication pazopanib and the pharmacist could not fill the medication until a pre-authorization was completed. The NP was notified and gave an order to hold the medication until available. Resident #1 was aware of the reason the pazopanib was on hold.</p> <p>Review of an order from the NP dated 04/24/2024 reflected pazopanib was on hold awaiting pre-authorization until the medication was available.</p> <p>Interview on 05/14/2024 at 11:33 am with the pharmacist, who was contacted by Resident #1's oncologist to fill Resident #1's pazopanib, revealed the pharmacy received an order from the oncologist on 05/09/2024 and the medication was ready to go except for insurance information.</p> <p>Interview on 05/16/2024 at 12:47 pm with Resident #1 revealed she knew she was not getting the medication because there was an insurance issue and the facility had to find a way to get the medication .</p> <p>Interview on 05/16/2024 at 1:07 pm with the Hospice Physician revealed the medication for pazopanib shoul [TRUNCATED]</p>