STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675964	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc Creekside	1433 Veterans Memorial Parkway Huntsville, TX 77340

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 Based on observation, interview, and record review, the facility failed to ensure the accurate administration of medications to meet the needs of each resident for 1 of 5 residents observed for medication administration. (Resident #19) MA B administered an incorrect dose of felodipine (used to treat high blood pressure) to Resident #19 on 03/04/25 during medication pass. This failure could place residents who received medications administered at risk of not receiving the intended therapeutic benefit of their medications. Findings included: Record review of a face sheet for Resident #19 indicated admitted to facility on 12/27/23 with diagnoses including high blood pressure and chronic kidney disease. Record review of Resident #19's annual MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. She required supervision from staff with ADL care. Record review of Resident #19's care plan initiated 01/15/25 indicated a diagnosis of high blood pressure. Interventions included give medicine for high blood pressure and document response to medication and any side effects. Monitor blood pressure. Notify physician of any abnormal readings. Record review of Resident #19's Physician Orders dated March 2025 indicated Resident #19 was to receive Felodipine ER 10 mg. Give with 5 mg to equal 15 mg to treat high blood pressure. Record review of Resident #19's MAR dated March 2025 indicated an order of Felodipine ER 10 mg. Give with 5 mg to equal 15 mg. During an observation of the medication pass on 03/04/25 at 7:45 a.m., MA B prepared and administered a felodipine 10 mg tablet to Resident #19. (continued on next page)

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/25 at 8:15 a.m., MA B acknowledged she had administered an incorrect dose of felodipine to Resident #19 during today's medication pass at 7:45 a.m. She said she gave one 10 mg tablet when she should have also given an additional 5 mg tablet to equal 15 mg, and she did not. During an interview on 03/05/25 at 9:45 a.m., the DON said he expected medications to be available and administered per physician orders. The DON said unstable vital signs could potentially be a negative result of not receiving correct dosage. Record review of the facility's Adverse Consequences and Medication Errors policy dated February 2023 read in part, .A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician orders. Examples of medication errors include wrong dose

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary medication for 1 of 14 residents reviewed for unnecessary medication (Resident #244) The facility did not monitor Resident #244 for side effects of the anticoagulation medication, Eliquis (a blood thinning medication). This failure could place the residents at risk for adverse consequences of the anticoagulant medication. Findings included: Record review of a face sheet dated 03/03/25 indicated Resident #244 was an [AGE] year-old male admitted [DATE] with a diagnosis of atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), and stroke (medical emergency that occurs when blood flow to the brain is blocked). Record review of a baseline care plan initiated 02/25/25 indicated Resident #244 was prescribed an anticoagulant medication. Record review of the physician orders dated 03/05/25 indicated Resident #244 was prescribed Eliquis 2.5 mg two times a day for a history of a blood clot with a start date of 02/25/25. The orders did not address monitoring the anticoagulant medication. Record review of a MAR dated 03/05/25 indicated Resident #244 received Eliquis 2.5 mg two times a day for history of a blood clot with a start date of 02/25/25. Record review of the electronic medical record from 02/25/25 to 03/05/25 for Resident #244 did not indicate the nurses' documented monitoring of side effects of the anticoagulant daily with medication administration. During an observation and interview on 03/03/25 at 10:25 a.m., Resident # 244 was up in his wheelchair with no observed bruised areas. He said he received the blood thinner Eliquis. During an interview on 03/05/25 at 9:10 a.m., LVN C said she was providing care for Resident #244 today and he received Eliquis. She said Resident #244 should be monitored for side effects of the anticoagulant medication, but he was not. LVN C said the monitoring was overlooked. She said she was educated to add side effect monitoring for all anticoagulant medication in the computer system. LVN C said the admitting nurse was responsible for adding the monitoring to the computer system and the nurses providing care for Resident #244 were the back up to ensure the monitoring for side effects was added into the computer system for Resident #244's Eliquis. LVN C said the resident's risk of not monitoring anticoagulants for side effects was the monitoring could be overlooked, and the resident could become anemic. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/25 at 9:25 a.m., Unit Manager A said she was responsible for adding the monitoring for Resident #244's Eliquis into the computer system. She said Resident #244's Eliquis should have been monitored for side effects, but he was not. Unit Manager A said she admitted the resident and the monitoring was overlooked. She said the DON was the back up to ensure anticoagulant medication monitoring was added into the computer system. She said she was educated to add side effect monitoring to all anticoagulant medication in the computer system. Unit Manager A said the resident risk of anticoagulant medication not monitored was possible bleeding and not being monitored for side effects. During an interview on 03/05/25 at 9:40 a.m., the DON said the admitting nurse was responsible for adding the anticoagulant monitoring into the computer system for all anticoagulants. She said the nurses providing care for the resident and himself were the back up to ensure side effect monitoring was added into the computer system for all anticoagulants. The DON said Resident #244's Eliquis should have been monitored for side effects, but was not. He said the monitoring was overlooked. The DON said all the nurses were educated to add side effect monitoring to all anticoagulant medications in the computer system with the most recent in-service on 12/18/24. He said the resident risk of anticoagulant medication monitoring not added into the computer system was possible bleeding and the staff being unaware to monitor for it. The DON said his expectation was all anticoagulant medication monitored for side effects on entry of the medication order. During an interview on 03/05/25 at 10:05 a.m., the Administrator said the nurses providing care for the resident were responsible for ensuring all anticoagulant medication was monitored for side effects, and the ADON and DON were the back to ensure the side effect monitoring was added into the computer system. He said the monitoring for Resident #244 was overlooked. He said the nursing staff were educated on adding monitoring for anticoagulant medication into the computer system. The Administrator said the resident risk was potential excessive bleeding and his expectation was all anticoagulant medication monitored as required. Record review of a facility policy titled, Anticoagulant - Clinical Protocol revised November 2018, indicated, 1. As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated, . a. assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. a. if an individual on anticoagulation therapy shows signs of excessive bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were labeled and stored in accordance with currently accepted professional principles in 1 of 2 medication carts reviewed. (Hall 200 Nurses medication cart) in that: An insulin pen of Lispro insulin (short acting insulin used to lower blood sugar) labeled for Resident #4 with an open date of [DATE], had been expired for 12 days and not removed from use. An insulin pen of Lispro insulin (used to lower blood sugar) labeled for Resident #31 with an open date of [DATE], had been expired for 29 days and not removed from use. This failure could place residents at risk for accidents, hazards, and not receiving therapeutic effects of medication. The findings included: 1. Record review of Resident #4's face sheet dated [DATE] indicated an [AGE] year-old female readmitted [DATE] with a diagnosis of type 2 diabetes mellitus (trouble controlling blood sugar). Record review of Resident #4's quarterly MDS assessment with an ARD of [DATE] indicated the resident had a BIMS score of 11 indicating the resident was moderately impaired of cognition. The assessment indicated she was diagnosed with diabetes mellitus and received insulin injections 7 of 7 days during the look back period. Record review of Resident #4's care plan updated [DATE] indicated she was diabetic and received diabetic medication as ordered by the physician and to monitor for side effects and effectiveness. Record review of Resident #4's physician order, dated [DATE], indicated she was prescribed Lispro 100 Units/ml Insulin 100 unit/ml inject solution (,d+[DATE] units) subcutaneous before meals. Inject as per sliding scale: if ,d+[DATE] = 2 units, ,d+[DATE] = 3 units, ,d+[DATE] = 4 units, ,d+[DATE] = 6 units, 401- 450 =8 units and if greater than 451 notify physician for type 2 diabetes mellitus. Resident #4 was prescribed Tresiba (long-acting insulin to lower blood sugar) insulin 100 unit/ml solution (10units) subcutaneous in the morning with a start date of [DATE] for type 2 diabetes mellitus. Record review of Resident #4's MAR, dated [DATE], indicated she received Lispro insulin per sliding scale on: *[DATE] at 5:00 p.m., 2 units; *[DATE] at 11:00 a.m., 2 units; *[DATE] at 5:00 p.m., 2 units; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*[DATE] at 7:30 a.m., 2 units; *[DATE] at 11:00 a.m., 3 units;and *[DATE] at 5:00 p.m., 3 units. During an observation and interview on [DATE] at 9:45 a.m., Resident #4 was sitting in her wheelchair and said she was treated well and received needed care. Resident #4 said she received insulin daily. 2. Record review of Resident #31's face sheet dated [DATE] indicated an [AGE] year-old female admitted [DATE] with a diagnosis of type 2 diabetes mellitus. Record review of Resident #31's annual MDS assessment with an ARD of [DATE] indicated the resident had a BIMS score of 11 indicating the resident was moderately impaired of cognition. The assessment indicated she was diagnosed with diabetes mellitus and received insulin injections 7 of 7 days during the look back period. Record review of Resident #31's care plan initiated [DATE] indicated she was diabetic and received diabetic medication as order by the physician and to monitor for side effects and effectiveness. Record review of Resident #31's physician order, dated [DATE], indicated she was prescribed Lispro Insulin 100 unit/ml inject solution (,d+[DATE] units) subcutaneous before meal. Inject as per sliding scale: if , d+[DATE] = 2 units, ,d+[DATE] = 3 units, ,d+[DATE] = 4 units, ,d+[DATE] = 6 units, 401 or greater = 8 units and notify physician for type 2 diabetes mellitus. Resident #24 was prescribed Tresiba Insulin 100 unit/ml solution (25 units) subcutaneous in the morning, hold for blood sugar less than 100, with a start date of [DATE] for type 2 diabetes mellitus. Record review of Resident #31's March MAR, dated [DATE], indicated he received Lispro insulin per sliding scale in March. *[DATE] at 5:00 p.m., 3 units; and *[DATE] at 11:00 a.m., 2 units. During an observation and interview on [DATE] at 9:05 a.m., Resident #31 was lying in bed and said he was treated well and received needed care. Resident #31 said he received insulin sometimes. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on [DATE] at 9:10 a.m., during a review of Hall 200 Nurse's medication cart with LVN C, revealed two insulin pens in use beyond the recommended time frame of use after opened. One Lispro kwick pen 100 U/ ml with 180 units in it, labeled with Resident #4's name with an expiration date of [DATE] and labeled with an open date of [DATE] on the medication cart 12 days after expiration. One Lispro kwick pen 100 U/ ml labeled with Resident #31's name, with an expiration date of [DATE] and labeled with an open date of [DATE] with 180 units on the medication cart 21 days after expiration. LVN C said both Lispro kwick pens should have been removed from the medication cart 28 days from the opening date, but they were overlooked. She said the nurses providing care to the residents were responsible to remove all expired medication. She said the ADON was a backup to ensure all expired medication was removed from the medication carts. LVN C said she was educated on removal of insulin in use beyond the recommended time frame of use after opened. She said she was providing care for Residents #31 and #4 today, and had not given either resident Lispro insulin today. LVN C said the resident risk of insulin, in use beyond the recommended time frame of use after opened, was the medication may not be as effective. During an interview on [DATE] at 09:30 a.m., the ADON, said the Lispro kwick pens expired 28 days after opening and should have been removed. She said the nurses providing care for the residents were responsible for and she was the back up to ensure any insulin, in use beyond the recommended time frame of use after opened, was removed from the nurse's medication cart. The ADON said the insulins, in use beyond the recommended time frame of use after opening, were overlooked. She said she was educated on removal of insulin in use beyond the recommended time frame of use after opened. The ADON said the resident risk of insulin in use beyond the recommended time frame of use after opened was the medication may be not as effective. During an interview on [DATE] at 9:44 a.m., the DON said the nurses were responsible for the removal of Lispro insulin on the nurses' medication cart, 28 days after the open date. He said the ADON was the back up to ensure no insulin, in use beyond the recommended time frame of use after opened, was on the nurse's medication cart and the pharmacy consultant checked random carts monthly for expired medication. He said the nurses were educated on removing expired medication off the nurse's medication cart with [DATE] being the most recent in-service. The DON said Resident #4 and #31's Lispro kwick insulin pens, in use beyond the recommended time frame of use after opened, were overlooked and should have been removed. He said the resident risk of insulin in use beyond the recommended time frame of use after opened was the medication may not be as potent as it should be. The DON said his expectation was all insulin removed at the beyond use date off the nurse's medication cart. During an interview on [DATE] at 10:12 a.m., the Administrator said the nurse administrating a resident's medication was responsible for ensuring insulin was removed after the beyond use date from the nurse medication cart, and the ADON and DON were the back up to double check. He said the nurses were educated to remove expired medication from their medication cart. He said the expired insulins were overlooked. The Administrator said the resident risk of insulin in use beyond the recommended time frame of use after opened was medication may not be as effective. He said his expectation was the nurses monitor the medication cart and remove all expired medication immediately. Record review of a facility policy titled, Medication Labeling and Storage revised February 2023 indicated, 3. If the facility has discontinued, outdated, or deteriorated medication or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility in-service titled, Pre-Survey Inservice dated [DATE] indicated, . Carts and {Medrooms} . Discontinued and expired meds removed Insulin Storage for Nursing Carts . Insulin type . Humalog, U- 100, U - 200 (Lispro) pens, vials, refillable pens . expiration dated once opened . 28 days . Record review of a web site titled, Humalog, insulin lispro injection 100 units/ ml Accessed on [DATE], https://insulins.lilly.com/ indicated, .used for the control of high blood sugar, . once opened, Humalog vials, prefilled pens, and cartridges should be thrown away after 298 days even if it still contains insulin.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22183 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for 1 of 1 kitchen reviewed for food service safety. The facility failed to close food product bags in the walk-in freezer, to prevent exposure to air. This failure placed residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings include: During initial observation and interview on 03/03/25 at 08:00 a.m., the walk-in freezer in the kitchen contained the following: *an open original cardboard box dated 02/27/25 containing a clear plastic bag of frozen beef patties that was not properly sealed and exposed to the elements. The Dietitian said it was beef patties. When asked about the frozen beef patties, the Dietitian tied the plastic bag and said it should be sealed. *an open original cardboard box dated 02/27/25 containing a clear plastic bag of fried frozen steak fritter patties that was not properly sealed and exposed to the elements. The Dietitian said it was fried steak fritters. *an open original cardboard box dated 02/27/25 containing a ripped open clear plastic bag of frozen French fries that was not properly sealed and exposed to the elements. The Dietitian said it was French fries. During an interview on 03/03/25 at 08:30 a.m., the Dietitian said her expectations was all products in the kitchen be stored correctly. She said packages of food items should be sealed so not to expose food to the elements. The Dietitian said it was the responsibility of all the dietary staff to ensure products were labeled and stored correctly. She said the EC (executive chef) was to monitor kitchen staff on storage, and preparation of food appropriately. The Dietitian said she did spot checks periodically in kitchen to be sure everything was working in kitchen and completed a walk-through checking for sanitary conditions. The Dietitian said she had not had time to do the walk-through today. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/03/25 at 11:00 a.m., the EC with contracted dietary services, said all products and packages of food should be stored in sealed containers after being opened. The EC said unsealed containers of food could cause food-born illnesses in residents and could affect the taste or quality of the food. He said it was the kitchen staff's responsibility to store, label and date food items taken out of the freezer to use. The EC said he was responsible for monitoring the kitchen staff and ensuring products were stored, labeled, dated and equipment cleaned. He also said he checked the tray line for portion sizes, tray accuracy, monitoring temperatures and staff following facility policy. The EC said some of the kitchen staff were new and he (EC) was trying to educate kitchen staff on storage, labeling, and dating food products. The EC said the kitchen staff had training on these topics, and knew what to do and what not to do in the kitchen. He said the kitchen staff had been changing and there was a new group which could have led to failures of staff may have forgotten their training. He said he felt more education was needed and would conduct a training. During an interview on 03/03/25 at 11:45 a.m., [NAME] D said she did not know who left the bags of foods opened in the freezer, and used bags of food being stored should be sealed or they could cause a person to get sick or food to taste funny. She said she had been trained that after opening a food item, it should be labeled with the opening date and stored in a sealed container. During an interview on 03/04/25 at 4:39 p.m., the Administrator said he expected kitchen staff to follow policies on food storage and preparation. He said the EC was responsible for monitoring kitchen staff and ensuring staff were following the facility's policy. He said not storing and preparing food appropriately could cause freezer burn, affecting the freshness and quality of resident's food. Review of a facility policy, revised January 2025, on Food and Supply Storage indicated Policies: All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain safety and wholesomeness of the food for human consumption . Procedures: Cover, label and date unused portions and open packages .store foods in their original packages. Foods that must be opened must be stored in approved containers that have tight-fitting lids .Store bulk material in approved containers that have tight fitting lids .wrap food tightly to prevent cross contamination .