

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Crestview Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 E Villa Maria Rd Bryan, TX 77802	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48314</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater when the facility had a medication error rate of 36.36% based on 16 errors of 44 opportunities, which involved 2 of 5 residents (Resident #8 and Resident #10) observed during medication administration.</p> <ol style="list-style-type: none"> 1. The facility failed to hold Resident #10's medication due to low heart rate. 2. The facility failed to ensure Resident #8's extended release (ER) medications were not crushed and the resident received the full dose of her medications. <p>These failures could place residents at risk of unwanted side effects and not receiving therapeutic dosage of medications.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Resident #10's face sheet reflected an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing), thrombocytopenia (low platelet levels), bradycardia (heart rate lower than 60 beats per minute), hypertension (elevated blood pressure) and edema (build-up of fluid in the body's tissues). <p>Review of Resident #10's Quarterly MDS assessment, dated 06/19/2024, reflected a BIMS score of 99 indicating resident was unable to complete the assessment.</p> <p>Review of Resident #10's physician orders reflected the order for Metoprolol (heart medication for blood pressure, which can lower heart rate) 50mg daily, hold for heart rate less than 60.</p> <p>Observation on 07/24/2024 at 07:11 AM revealed LVN A check the vital signs for Resident #10 (HR 54, BP 141/62) LVN A then crushed and administered Metoprolol 50mg via PEG tube for Resident #10 when his heart rate was 54.</p> <p>In an interview on 07/24/2024 at 09:25 AM, LVN A stated the Nurse Practitioner verbally told her (date/time unknown) to give Resident #10's metoprolol dose if the HR was above 50. LVN A acknowledged the current order in the chart reflected hold for heart rate less than 60 and she should have had the order changed before administering the medication. LVN A acknowledged the potential for adverse effects such as the heart rate dropping too low.</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of Resident #8's Face Sheet reflected a [AGE] year-old female admitted on [DATE] with diagnoses of type 2 diabetes (condition in which the body has trouble regulating blood sugar), atrial fibrillation (irregular, often very rapid heart rhythm), history of cerebral infarction (stroke), speech and language deficits, and dementia (a group of symptoms affecting memory, thinking and social abilities).</p> <p>Review of Resident #8 's Comprehensive MDS assessment, dated 03/07/2024, reflected a BIMS score of 10 indicating moderate cognitive impairment. MDS further reflected resident requires some partial assistance with functional abilities.</p> <p>Review of Resident #8's Comprehensive Care Plan reflected a problem with resident refusing medications at times, dated 07/24/2024. Interventions included to find out why resident refused and adjust scheduling to encourage a positive outcome. Care Plan also reflected resident had a problem with hypertension (high blood pressure) and heart disease, dated 03/13/2024, and should have anti-hypertensive medications and cardiac medications administered as ordered.</p> <p>Observation on 07/24/2024 at 07:37 AM, MA B administered medications to Resident #8. MA B crushed all 12 of the medications (Eliquis, Sodium Bicarb, Aspirin, Vit B-12, Glipizide ER, Metformin, Amlodipine, Bupropion ER, Farxiga, Folic Acid, Metoprolol ER, and Finerenone) and mixed them together with one spoonful of pudding in a small cup. Resident #8 was able to swallow one bite of medications with the pudding. When MA B gave Resident #8 the second bite followed by a sip of water, she held the pudding/medications in her mouth and then spit them out into a cup. Resident #8 received approximately half of the medications. MA B documented in the chart that the resident only received half of her medications and notified LVN A.</p> <p>In an interview on 07/24/2024 at 09:45 AM, MA B stated she always crushes Resident #8's medications and mixes them together with pudding. MA B stated the resident often refuses her medications and the doctors are aware she does not get them all the time. MA B further stated she always charts when Resident #8 refuses or does not receive all of her medications.</p> <p>In an interview and observation on 07/24/2024 at 12:30 PM, Resident #8 stated she usually takes her medications crushed. Resident #8 stated she never receives any of her medications whole. Resident #8 stated she was having difficulty swallowing the medications this morning, so she spit them out. Resident #8 was observed sitting up in chair watching television with no signs of acute distress.</p> <p>In an interview on 07/25/24 at 02:55 PM, DON stated the MAs sometimes crush the medications and mix them together, it just depends on the resident and the situation . The DON stated for residents that sometimes spit out the medication, it would be better to administer the critical ones separately to ensure they know how much and which ones the resident actually received. The DON stated she would expect staff to follow the orders in the chart because you can't verify verbal orders.</p> <p>In an interview on 07/25/24 at 03:27 PM, Administrator stated a pharmacy consultant comes in monthly and reviews medication administration and reports any errors and also provides training to the staff. The Administrator stated he expects the staff to follow the orders as written and the order for Resident #10's Metoprolol should have been changed to reflect the appropriate holding parameters prior to administering the medication.</p> <p>(continued on next page)</p>		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of training records dated 02/14/2023 reflect MA B was trained on medication administration and proper technique for crushing medications. Review of Adverse Consequences and Medication Errors facility policy, dated 2001, reflected a medication error defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles.		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48314</p> <p>Based on observation, interview, and record review, the facility failed to ensure that its residents were free of any significant medication errors for one (Resident #8) of five residents reviewed for significant medication errors.</p> <p>The facility failed to ensure Resident #8's extended release (ER) medications, including Glipizide 2.5mg ER, Bupropion 300mg ER, and Metoprolol Succinate 50mg ER were not crushed prior to administration and that Resident # 8 received the full dose of her medications.</p> <p>These failures could place residents at risk of unwanted side effects, not receiving therapeutic dosage of medications, and ineffective disease management.</p> <p>Findings include:</p> <p>Review of Resident #8's Face Sheet reflected a [AGE] year-old female admitted on [DATE] with diagnoses of type 2 diabetes (condition in which the body has trouble regulating blood sugar), atrial fibrillation (irregular, often very rapid heart rhythm), history of cerebral infarction (stroke), speech and language deficits, and dementia (a group of symptoms affecting memory, thinking and social abilities).</p> <p>Review of Resident #8's Comprehensive MDS assessment, dated 03/07/2024, reflected a BIMS score of 10 indicating moderately cognitive impairment. MDS further reflects resident requires some partial assistance with functional abilities.</p> <p>Review of Resident #8's Comprehensive Care Plan reflected a problem with resident refusing medications at times, dated 07/24/2024. Interventions included to find out why resident refused and adjust scheduling to encourage a positive outcome. Care Plan also reflected resident had a problem with hypertension (high blood pressure) and heart disease, dated 03/13/2024, and should have anti-hypertensive medications and cardiac medications administered as ordered.</p> <p>Observation on 07/24/2024 at 07:37 AM, MA B administered medications to Resident #8. MA B crushed all 12 of the medications, including 3 extended-release tablets (Glipizide 2.5mg ER (for diabetes), Bupropion (antidepressant) 300mg ER and Metoprolol Succinate 50mg ER (heart medication for blood pressure control), and mixed them together with one spoonful of pudding in a small cup. Resident #8 was able to swallow one bite of medications with the pudding. MA B gave her the second bite followed by a sip of water, Resident #8 held the pudding/medications in her mouth and then spit them out into a cup. Resident #8 only received approximately half of the medications. MA B documented in the resident electronic medical chart that Resident #8 only received half of her medications and notified LVN A.</p> <p>In an interview on 07/24/2024 at 09:25 AM, LVN A stated that MA B should not have crushed the ER tablets because Resident #8 would get a large dose at one time which could drop her blood pressure. LVN A stated she was told by MA B that she administered the ER tablets whole with pudding and crushed the rest because Resident #8 pockets the tablets if they are not crushed.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 07/24/2024 at 09:45 AM, MA B stated she always crushes Resident #8's medications and mixes them together with pudding. MA B stated she normally crushes the extended-release tablets. MA B said she should not have crushed the ER tablets.</p> <p>In an interview on 07/24/24 at 10:00 AM, the DON stated MA B should not have crushed the ER tablets for Resident #8 and they notified the pharmacist and the doctor and will monitor her throughout the day for any side effects , such as low heart rate, low blood sugar and low blood pressure. The DON provided a copy of a drug regimen review, dated 07/24/2024, from the pharmacist to the physician which reflected orders to change the ER tablets to immediate release tablets. The DON provided in-service training completed 07/24/2024 for MA B which reflected training regarding the negative outcomes that can occur by crushing ER medications.</p> <p>In an interview and observation on 07/24/2024 at 12:30 PM, Resident #8 stated she usually takes her medications crushed. Resident #8 stated she never received any of her medications whole. Resident #8 stated she was having difficulty swallowing the medications this morning, so she spit them out. Resident #8 was observed sitting up in chair watching television with no signs of acute distress.</p> <p>In an interview on 07/24/2024 at 02:00 PM, the Medical Director stated she was notified by several people from the facility regarding the ER medication error for Resident #8. The Medical Director was aware the ER tablets were crushed with all of the resident's medications and that she spit out most of them. The Medical Director stated the potential adverse effects of crushing ER tablets were, it essentially changes the ER to immediate release. No expected harm with the medications she received. The Medical Director stated her 3rd year medical resident was at the facility at the time of the incident and evaluated the resident with no concerns. The Medical Director stated she was at the facility around lunch time and checked on the resident as well with no adverse effects noted. She also stated the resident's primary physician, and the pharmacist were notified, and the orders were changed to immediate release tablets. The Medical Director stated the potential negative impact from switching medication was, there aren't really any, they just give the medication twice a day instead of once a day. She stated this has never happened before and usually the MA's are very proactive and notify her if the ER order needs to be changed. The Medical Director stated she was not aware of any adverse effects from medication errors in the facility in the last 6 months.</p> <p>In an interview on 07/25/24 at 03:10 PM, MA C stated the nurses and MAs are trained regularly on medication administration and the MAs have taken the medication administration course. She stated ER medications should not be crushed because the resident would receive all of the medication at one time and it should be released over a period of time.</p> <p>In an interview on 07/25/24 at 03:27 PM, the Administrator stated the ER medications should not be crushed because it takes away the extended-release action and could result in severe consequences to the resident. The Administrator stated a pharmacy consultant comes in monthly and reviews medication administration and reports any errors and also provides training to the staff.</p> <p>Review of Adverse Consequences and Medication Errors facility policy, dated 2001, reflected a medication error defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles. to include crushing a do not crush medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of training records dated 02/14/2023, reflected MA B was trained on 02/14/2023 in medication administration and proper technique for crushing medications.</p> <p>Review of the Institute for Safe Medication Practices ISMR Long-Term Care Advise, dated 2017, reflected As a general principle, any tablet that is labeled extended-release or sustained release should not be crushed or split. This is because crushing or splitting will damage the tablets' properties, causing immediate release of a large dose of medication that would otherwise have been released over a longer period of time.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48314</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen reviewed for sanitation.</p> <p>The facility failed to discard of food products in the walk-in freezer that were past their facility indicated use by date.</p> <p>The facility failed to label and date food products in the walk-in freezer.</p> <p>The facility failed to clean their industrial can opener.</p> <p>These failures could place residents at risk of cross contamination, loss of nutritional value, and foodborne illness.</p> <p>Findings included:</p> <p>Observation on [DATE] at 8:29 AM, of the facility's walk-in freezer revealed the following food products that were past their displayed use by date or were not labeled:</p> <p>1 metal tray covered with plastic wrap that was labeled breaded cod, opened [DATE] at 5:55 PM and discard [DATE] at 5:55 PM.</p> <p>1 metal tray labeled Fish, Salmon 6oz, opened [DATE] at 5:55 PM and discard [DATE] at 5:55 PM, which contained 38 individually wrapped pieces of fish.</p> <p>1 plastic bag labeled Fish, Salmon Fillet Raw opened [DATE] at 6:20 PM and discard [DATE] at 6:20 PM. The bag contained small pieces of fish, some of which had visible ice crystals on them.</p> <p>1 plastic wrapped food product labeled Pork opened [DATE] at 12:42 PM and discard [DATE] at 12:42 PM.</p> <p>1 metal tray with 2 sealed plastic bags that contained what appeared to be chicken wings but had no identification label or dates on them.</p> <p>1 metal tray with 2 plastic wrapped food products labeled, Veal, Liver Raw [DATE] at 3:06 PM and discard [DATE] at 3:06 PM.</p> <p>Observation on [DATE] at 8:39 AM, of an industrial can opener mounted to a prep table at the back of the kitchen revealed a sticky substance on and around the cutting blade.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and observation on [DATE] at 8:51 AM, the Dietary Manager stated the facility's refrigerators and freezers were supposed to be checked daily by the supervisors to ensure there were not out of date or expired food products present. The Dietary Manager checked the freezer and stated that the observed out of date items should have been discarded. The Dietary Manager stated even if they were incorrectly labeled their discard dates had been reached and they should not have been present. The Dietary Manager stated the two unlabeled plastic bags did contain chicken wings and that they should have been labeled as such with the date in and a discard by date. The Dietary Manager stated labeling of food is important to ensure that staff know what the food product is. The Dietary Manager stated failure to properly discard of expired food products could result in a resident getting sick, loss in nutritional value, and possible freezer burn. The Dietary Manager stated the industrial can opener is inspected and replaced by a company, but they should be cleaning it daily. The Dietary Manager stated failure to properly clean the industrial can opener could result in contamination.</p> <p>Interview on [DATE] at 9:01 AM, the Chef stated their industrial can opener not being properly cleaned could lead to food product contamination. The Chef stated any food products in the facility's freezers and refrigerator that are past their use by date should be discarded immediately. The Chef stated that service of out-of-date food products could result in a loss of nutritional value, affect taste, and appearance. The Chef stated he and everyone who works in the kitchen is responsible for labeling and storage of food products and should ensure that out of date food products are discarded.</p> <p>Interview on [DATE] at 8:30 AM, the Lead [NAME] stated items placed in the freezer needed to be labeled to identify the product as well as have the date in and a discard date. The Lead [NAME] stated the date to discard for frozen items can be different for them but that if it is past the displayed date it must be discarded. The Lead [NAME] stated everyone in the kitchen is responsible for ensuring that food products are properly labeled, dated, and discarded when past their use by date. The Lead [NAME] stated service of expired food products could result in a resident become sick or the food losing nutritional value.</p> <p>Follow-up interview on [DATE] at 8:37 AM, the Chef stated he did not have an in-service training for labeling and storage he could provide but stated they do discuss it in morning meetings.</p> <p>Interview on [DATE] at 3:14 PM, the Administrator stated he expects food products in the kitchen to be labeled and dated appropriately. The Administrator stated nothing should be present in the kitchen that is past the use by or manufacturer's expiration date. The Administrator stated even if a product was dated it error it should still be discarded because, better safe than sorry. The Administrator stated failures in labeling and storage could result in illness for a resident that consumes it.</p> <p>Review of the facility's Food Safety and Quality Assurance Standards Manual dated [DATE] revealed, 5.3 DATING & LABELING OF FOOD IN PRODUCTION. Standard - All foods, including prepared items, bulk foods, frozen foods, and ingredients present in a [facility] must be labeled at all times. - [Facility] foods requiring a date mark shall be labeled with the common name, preparation date, discard date, and associate initials. 5.4 FOOD EXPIRATION & ROTATION. Stock must be rotated to ensure that older foods are used first, this method is often called FIFO or First In, First Out. Standard - Foods that have expired must be discarded and not used or served. This includes both manufacturer and unit-labeled food expiration dates on dry, refrigerated and frozen foods.</p> <p>(continued on next page)</p>		

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