

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675980	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Hill Country Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 W Hwy 290 Dripping Springs, TX 78620	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observation, interview, and record review, the facility failed to ensure all alleged violations involving abuse or neglect were reported immediately or no later than 24 hours for one (Resident #1) of four residents reviewed for abuse and neglect, in that:</p> <p>The facility failed to report to HHSC an allegation that Resident #1 was overdosed with opioid medication.</p> <p>This failure could place residents at risk of abuse or neglect.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including type II diabetes, paranoid schizophrenia, major depressive disorder, history of heart attack, hypertension (high blood pressure), chronic pain, and age-related physical debility.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 05/04/24, reflected a BIMS of 6, indicating a severe cognitive impairment. Section J (Health Conditions) reflected he had occasional pain and received PRN pain medication.</p> <p>Review of Resident #1's quarterly care plan, revised 02/05/24, reflected he experienced severe/almost constant pain at times with an intervention of administering medications as ordered by physician.</p> <p>Review of Resident #1's physician order, dated 02/08/24, reflected Fentanyl Transdermal Patch 72 Hour 25 MCG/HR - Apply 2 patches trans dermally every 72 hours for pain related to chronic pain syndrome.</p> <p>Review of Resident #1's physician order, dated 04/29/24, reflected Fentanyl Patches were discontinued.</p> <p>Review of Resident #1's progress notes in his EMR, dated 04/28/24 at 10:45 AM and documented by LVN A, reflected the following:</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675980	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Hill Country Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 W Hwy 290 Dripping Springs, TX 78620	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>After breakfast, CNA report [Resident#1] has a white substance in his mouth - nothing missing from his tray. [Resident #1] unable to swallow. Cleaned out mouth. He is difficult to arouse. Grip strength intact - able to follow that command. Able to follow finger with right eye, but he is not opening left eye on command . BG taken: first attempt read Low second attempted 68. On-call paged, awaiting call back with further instruction.</p> <p>Review of Resident #1's progress notes in his EMR, dated 04/28/24 at 11:12 AM and documented by LVN A, reflected the following:</p> <p>Called EMS r/t declining clinical status as noted previously .</p> <p>Review of Resident #1's EMS records, dated 04/28/24, reflected the following:</p> <p>[Resident #1]'s airway was open w/ decreased respiratory effort noted .</p> <p>NH staff stated that they have been unable to wake [Resident #1] up this morning, and that he has been lethargic. Staff stated they had noticed that [Resident #1] had shallow respirations. The staff denied any recent illness, fever, or trauma, and no trauma was noted.</p> <p>EMS located a Fentanyl patch on [Resident #1]'s L shoulder and removed the patch.</p> <p>.Placed [Resident #1] on O2 at 2 LPM via ETC02 N/C . Administered 1 mg Narcan via IN route . En route [Resident #1] begins to wake up and is A&O to self with GCS of 14 .</p> <p>Review of Resident #1's ER records, dated 04/28/24, reflected the following:</p> <p>Altered mental status due to opiate overdose.</p> <p>During an observation and interview on 05/16/24 at 10:02 AM, revealed Resident #1 in his room. He was pleasantly confused and did not remember going to the hospital recently.</p> <p>During an interview on 05/16/24 at 1:11 PM, the ADM stated he would make a report to HHSC when there was an allegation of abuse, neglect, actual harm, or a drug diversion. He stated he learned of the allegation of a drug overdoes for Resident #1 on Monday, 04/29/24. He stated due to him being on the correct dosage of Fentanyl that he had been on for months and the hospital not doing any blood work, he and his team believed it was just an allegation as there was no proof. He stated failing to report to HHSC when necessary, could lead to something slipping through the cracks or actual abuse or neglect of residents taking place.</p> <p>Review of the facility's undated Abuse and Neglect Policy, reflected the following:</p> <p>Purpose: To ensure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, involuntary seclusion and misappropriation of resident's belongings or money.</p> <p>Procedure: The Administrator and/or Designee is responsible for maintaining ALL facility policies that prohibit abuse, neglect, involuntary seclusion and misappropriation of resident's property to include the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675980	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Hill Country Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 W Hwy 290 Dripping Springs, TX 78620	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>.</p> <p>Reporting of Incidents, investigations and facility response to results of investigations to all appropriate regulatory entities.</p>