STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675989	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brazos Valley Care Home	605 S Ave F Knox City, TX 79529

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 04033 Based on observation, interview, and record review; the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles when applicable for 2 of 7 residents (Resident #1 and #2) reviewed for pharmacy services. The facility failed to prevent the misappropriation of Resident #1's Depakote (Divalproex for mood/behavior), when LVN A took a blister pack of Depakote from Resident #2 and placed Resident #1's pharmacy label on top of Resident #2's pharmacy label. This failure could place residents at an increased risk for not receiving their prescribed medication as ordered. This failure could result in residents not receiving an accurate dose of medication as well as not being maintained at their best therapeutic level. Findings include: Record review of Resident #1's Resident Face Sheet dated 09/05/24 indicated she was a [AGE] year-old female who was admitted to the facility 05/05/16. Resident #1 diagnoses included Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), mild cognitive impairment (early stage of memory loss or other cognitive ability loss), and generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities). Record review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE] revealed she scored a 99 on her Brief Interview for Mental Status (BIMS), because she was unable to complete the interview; Section E indicated she displayed physical behavioral symptoms towards others (hitting, kicking, pushing, scratching, grabbing, and abusing others sexually) every one to three days. Record review of Resident #1's Care Plan dated 06/19/24 indicated on 06/18/24 Divalproex for mood/behavior was included to this plan. Record review of Resident #1's Prescription Order dated 02/09/24 revealed an order for Divalproex sprinkles, delayed release sprinkles, 125 milligrams (mg) amount: 4 capsules, oral. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Medication Administration Record dated 08/01/24 to 08/31/24 included Divalproex sprinkles capsule, delayed sprinkles, 125 mg, administer 4 capsules orally at 5:30 pm, and 3 capsules orally at 9 am and 12 pm. The record indicated Resident #1 was administered the medication throughout August 2024. Record review of Resident #1's Progress Note dated 08/24/14 indicated the pharmacy was contacted by the DON and questioned as to why Resident #1's Divalproex was not sent when it was ordered on 08/22/24. The Pharmacist stated it was too soon to fill the order; however, once the pharmacist clarified the order, he would send backup medication. -Record review of Resident #2's Resident Face Sheet dated 09/05/24 indicated he was a [AGE] year-old-man admitted to the facility on [DATE] and readmitted [DATE]. Resident #2's diagnoses included neuroleptic parkinsonism (parkinsonism symptoms develop because of taking neuroleptic drugs/antipsychotics), schizoaffective disorder, (symptoms of hallucinations, delusions, and mood disorders) and cognitive communication deficit (difficulty with communication that's caused by a problem with cognition). Record review of Resident #2's Quarterly Minimum Data Set (MDS) dated [DATE] revealed he scored a 3 on his BIMS, indicating he had severe cognitive impairment. Record review of Resident #2's Care Plan dated 06/19/24 indicated on 08/29/24 medication (not specified) for his schizoaffective disorder bipolar type was added to this plan. Record review of Resident #2's Prescription Order dated 07/26/24 with start dated 07/26/24 included Depakote (Divalproex) capsule, delayed release sprinkle, 125 mg: amt: 4 caps: oral, once a day at 1:00 pm, for schizoaffective disorder, bipolar type related to aggressive/combative behavior. Record review of Resident #2's Medication Administration Record dated 08/01/24 to 08/31/24 included Divalproex sprinkles capsule, delayed sprinkles, 125 mg, administer 3 capsules orally at 9 am and 6 pm, and 4 capsules orally at 1 pm. The record indicated Resident #2 was administered the medication throughout August 2024. Record review of LVN B's written statement dated 08/24/24 at 5:14 pm indicated she informed the Director of Nurses (DON) that she discovered Resident #1's Depakote blister pack label was placed on top of Resident #2's Depakote blister pack label. LVN B indicated the StatSafe (facility's e-kit with back up medications) supply had enough to administer the medication as needed. On 08/21/24 LVN B said she notified the DON that Resident #1 would run out of Depakote on 08/21/24 and she had ordered the medication. LVN B said she was reminded by the DON that she should utilize StatSafe supply to prevent Resident #1 from missing her medication. Record review of LVN A's written statement dated 08/25/24 indicated she ordered Resident #1's Divalproex on 08/22/24; however, it was not delivered. LVN A said she borrowed Resident #2's Divalproex because he had 10 blister packs of the medication and once the medication was delivered for Resident #1, she would return a blister pack to Resident #2. LVN A said she did not want Resident #1 to miss her dosage of Divalproex because of her behaviors. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation 0n 9/05/24 at 5:15 pm of Resident #2's Divalproex blister pack revealed it had Resident #2's label, which included Resident #2's name, room number, Divalproex 125 mg capsule (sprinkle), the brand: Depakote 125 mg capsule, and administer 3 capsules by mouth twice daily. On top of this label was Resident #1's label that had Resident #1's name, room number, Divalproex 125 mg capsule (sprinkle), the brand: Divalproex 125 mg capsule and administer 3 capsules by mouth twice daily at 9 am and 1 pm, and expiration date 07/30/25. During an interview on 09/05/24 at 1:55 pm with LVN A indicated on 08/24/24 at 5:14 pm she borrowed 1 card of Divalproex from Resident #2 to prevent Resident #1 from not receiving her Divalproex on the next shift, if case the pharmacy did not deliver this medication on time. Once Resident #1's Divalproex was delivered, she was going to return the new blister pack to Resident #2. LVN A said she was not aware Resident #1's Divalproex was increased and that's why she ran out early. LVN A said she did not notify Resident #1's physician or the DON that she was taking Resident #2's Depakote to give to Resident #1, and she knew that was not ok; however, Resident #1 needed it. LVN A said she did not administer Resident #2's medication to Resident #1, she was just making sure the next shift nurse had the medication to administer to Resident #1. LVN A said that was the first time she had ever taken a resident's medication to give to a different resident. During an interview on 09/05/24 at 4:55 pm with the Pharmacist indicated he had received a request to refill Resident #1's Divalproex on 08/24/24; however, it was after the pharmacy had closed. On 08/25/24, after receiving a call from the DON, he clarified Resident #1's multiple orders for Divalproex and then refilled the Divalproex . The Pharmacist said he would not advise anyone to change prescription labels between residents' blister packs and said there was a warning statement that's included on the blister packs that reflected: Caution/Warning: Federal and/or State law prohibits the transfer of this drug to any person other than patient for whom it was prescribed. During an interview on 09/05/24 at 4:09 pm with the DON said she was informed by LVN B that Resident #1 was running out of her Depakote, and she had ordered it. The DON said she called the pharmacy and questioned why Resident #1's medication was not refilled, and he said it was not time. Afterwards the pharmacist clarified Resident #1's Depakote order and confirmed he would immediately send the medication to the facility. The DON said the StatSafe had 10 Depakote capsules to use during an emergency and there was no need to take Resident #2's Depakote to give to Resident #1. The DON said Residents #2's Depakote was never administered to Resident #1 because the pharmacist sent the backup supply to the facility before Resident #1 ran out of her Depakote. The DON said she audited the residents' medications and found no concerns, nor did she discover any medication blister packs with a label belonging to a different resident. During an interview on 09/05/24 at 3:03 pm Physician C indicated he was informed LVN A placed Resident #1's label over Resident #2's label that was on his Depakote blister pack. Physician C said medically Resident #1 was not harmed, but administratively it was not appropriate for the nurse to borrow medication from a resident to give to another resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Policy Statement for Labeling of Medication Containers dated 08/26/24 included All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. The label must include the name of the resident and physician, (Note: the name of the resident and physician do not have to be on each unit dose package, but [NAME] be identified within the package in such a manner as to ensure that the drug is administer to the right resident. And only the dispensing pharmacy can label or alter the label on a medication container or package. The facility's Policy Statement for Emergency Medications dated April 2021 included that the emergency medication kit will include medication and biologicals that are essential in providing emergency treatment, and a physician's order is required to administer emergency medications and biologicals from this kit.