

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Southern Specialty Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 W 19th St Lubbock, TX 79407	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03896</p> <p>Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys, for 1 of 6 medication carts (Hall 200), in that:</p> <p>The facility failed to ensure that the Hall 200 medication cart was secured when unattended.</p> <p>These failures could result in the theft or misuse of medications.</p> <p>The findings include:</p> <p>Observation on 6/27/24 at 11:54 AM, revealed a medication cart was left unlocked and unattended in Hall 200 in the corridor between room [ROOM NUMBER] and the Hall 200 nurse's station. The cart was against the east wall with the unlocked drawers of medications facing the public access walkway of the hall. This cart was full of hall 200 resident medications. The surveyor alerted LVN A on 6/27/24 at 11:56 AM and he went to look for the nurse for Hall 200. RN A was observed leaving room [ROOM NUMBER] where he had been with a resident and returned to the cart on 6/27/24 at 11:57 AM.</p> <p>During this visit, cognitively impaired, independently ambulatory residents were observed ambulating the facility corridors at random times throughout the day on 6/27/24, which included Resident #1 at 9:52 AM and Resident #2 at 9:59 AM.</p> <p>On 6/27/24 at 11:59 AM an interview was conducted with RN A, nurse for nurse station 200. Regarding the unlocked medication cart, he stated, Sometimes I get in a rush and forget. I keep the key with me. He stated he left the cart unlocked because he was in a rush. He added, I should have locked it. He stated he had received training at the facility, a couple of weeks ago, regarding medication counts, securing the medication cart keys and locking the cart. He further stated he, and the nurses who have the (medication cart) keys, were responsible for ensuring the security of medications in the cart. He also stated, residents could come in and take medicine and staff too as a result of leaving the medication cart unlocked.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 5:22 PM an interview was conducted with the DON regarding medication security. She stated RN A was not following facility protocol and policies by leaving the medication cart unlocked. Regarding training on medication security, she stated, Yes, one (in-service) was done on 3/28/24 stating to lock the cart. Anytime it is locked the key should be in their pocket, and they should secure and lock the cart at all times. She stated every nurse and medication aide in possession of the cart was responsible for ensuring the security of the medications in the cart. She added the DON should ensure they follow the policy. She stated, residents could get in the cart and could have a reaction to the medication and pass away as a result of accessing medication on an unlocked cart. She further stated that the facility's population was younger and more active, and the active residents were more likely to be out and possibly see the unlocked medication cart. She stated, she and the ADON walked halls and conducted reeducation as a means of monitoring medication security.</p> <p>Record review of the In-Service Training Report dated 6/20/24 given by the Administrator, DON and ADON revealed a Subject documented as, Medication Misappropriation/Securement of Medication/Narcotic. The Summary of Subject Matter was documented as, Did you know that taking any medication that belongs to a resident from the cart is misappropriation and is punishable by actual prison time? Medications for long-term care residents are provided and paid for by Medicaid, which is funded by the State of Texas. Think before taking anything from a resident. When you receive keys, you are taking ownership of those narcotics. You must always keep narcotic key secure on person. If you leave the property on your lunch break, or you do not want to be disturbed on your lunch break, you MUST count with nurse covering and leave them the keys. You must always keep your cart locked anytime you are away from it. Documentation on the report revealed that RN A attended this in-service.</p> <p>Record review of the facility policy titled Pharmacy Policy and Procedure Manual 2003, PA 03-4.02, Revised 10/25/17 revealed the following documentation, Medication Administration Procedures . 5. During the medication administration process, the unlocked side of the cart must always be in full view of the nurse 8. After the medication administration process is completed, the medication cart must be completely locked, or otherwise secured .</p>		