STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676035	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingsland Hills Care Center	3727 W Ranch Rd 1431 Kingsland, TX 78639

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on observations, interviews, and record review the facility failed to ensure that the medication error rate was not 5% or greater. The facility had a medication error rate of 9.38% based on 3 errors out of 32 opportunities, which involved 2 of 4 residents (Resident #3 and #13) reviewed for medication errors. The facility failed to ensure LVN-A administered medications according to physician's order and manufactured guidelines for resident #13 when LVN-A crushed an extended release medication and failed to ensure a medication was in the medication cup. LVN-A failed to give resident #03 the correct number of tablets. This failure could place residents at risk for incorrect dosages resulting in reduced healing and unnecessary hospitalization s. Findings include: 1. Record review of Resident #13's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of Senile degeneration of brain, Anxiety disorder, Congestive Heart Failure, and Respiratory Failure. Record review of Resident #13's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 11, which indicated the resident's cognitive ability was moderately impaired. Record review of Resident #13's Care Plan, reflected a Focus area was initiated on 1/22/2025 for resident having impaired cognitive function/dementia. Her goal was to improve current level of cognitive function. Record review of Resident #13's orders reflected a 10/30/24 order for Desvenlafaxine Succinate (antidepressant) Tablet Extended Release 24 hour: 100mg oral tablet daily. Order reflects Do Not Crush. Record review of Resident #13's orders reflected a 11/05/2024 order for Lorazepam-Schedule IV tablet: 0. 5mg: 1 orally twice daily. 2. Record review of Resident #3's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of Chronic pain, Repeated falls, Diabetes Type II, Chronic Obstructive Pulmonary Disease (lung disease), and Bipolar disease. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the resident's cognitive ability was intact. Record review of Resident #3's orders reflected a 4/19/2024 order for Torsemide tablet (fluid pill) 20mg-3 tablets once daily. Observation of medication pass on 3/12/2025 at 8:43 AM, revealed the following for Resident #13: 1. LVN-A crushed a Desvenlafaxine succinate Tablet Extended Release 24-hour 100mg tablet and administered it to Resident #13. 2. LVN-A failed to ensure a Lorazepam 0.5mg tablet was in the medication cup. Examination revealed the tablet had not fallen out of the packaging. Observation that the narcotic count was 3 versus the 4 seen in the pack by the surveyor revealed the error and it was corrected. Observation of medication pass on 3/12/2025 at 9:28 AM, revealed the following for Resident #03: 1. LVN-A placed 2 Torsemide 20mg tablets into Resident #3's medication cup. When her medications were completed and count was verified by Surveyor, the cup was short 1 Torsemide. Observed LVN-A correcting the error and adding the 3rd Torsemide to the cup . In an interview with LVN-A on 03/12/25 at 09:06 AM, he stated that the medications in the cup for Resident #13 were completed and he was ready to give the medications. He stated, he Desvenlafaxine ER 100 was allowed to be crushed, he stated the resident has to have all medications either crushed or capsules opened. When he was asked by surveyor if crushing the medication could affect the medication time release, he stated unsure and proceeded to give the medication. In an interview with LVN-B on 3/13/2025 at 1:18 PM, she stated, the policy was to administer medications exactly as the order was written and that was important to maintain patient safety. She stated that administering a fluid tablet incorrectly could cause a resident to have fluid overload, electrolyte imbalances, or respiratory problems. She further stated that administering an anti-anxiety medication incorrectly could cause a resident to withdraw (socially) and refuse therapy. She stated it was standard practice not to crush extended-release medications and that it could cause the resident to get medications release too fast and have burning. She stated the dose would be changed if crushed. In an interview with DON on 3/13/25 at 1:44 PM, she stated the policy for is that when a nurse receives an order, she is to put them in the computer and follow the order. She said changing an order must be clarified with a physician. She stated it was important to follow doctor's orders exactly to prevent medication errors, prevent harm to the resident and so the medication could fix what it was intended for. She stated that administering a fluid tablet incorrectly could cause a resident to retain fluid and could cause a hospitalization . She further stated that administering an anti-anxiety medication incorrectly could cause a resident emotional harm or could cause them to harm themselves or others. She stated it was standard practice not to crush extended-release medications, but an alternative medication should be obtained for the resident if required. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADM on 3/13/25 at 1:28 PM, he stated the policy was to follow physician's orders exactly to administer medication as indicated on the Medication Administration Record. He stated this was important because the physician was the person overseeing the clinical care of the resident and if the order was not followed, the medication wouldn't have the intended effect on the resident. He stated the resident's health outcome could be changed and an example if a fluid pill was not given correctly, was that a resident could have fluid retention. Interview attempted with RPH (Pharmacy Rep) on 3/13/25 at 2:05 PM. A message was left but no return call received. A record review of the facility policy titled, Nursing Policy and Procedure-Medication Administration dated 10-2020 reflected the following: It is the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations. If it is safe to do so, medication tablets may be crushed. Record review of manufacture package insert for Desvenlafaxine-Extended-Release tablets reflected the following: Take tablets whole; do not divide, crush, chew, or dissolve.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections for 4 of 4 residents (Resident #1, #3, #13, and #51) reviewed for infection control. The facility failed to ensure LVNA sanitized equipment/work surfaces between Residents #1, #3, #13, and #51. This failure could place residents at risk for development of communicable diseases and infections. Findings included: 1. Record review of Resident #1's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of Vascular Dementia, High Blood Pressure, Stroke affecting Right dominant side, Alzheimer's disease and lack of coordination. Record review of Resident 01's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 10, which indicated the resident's cognitive ability was moderately impaired. Record review of Resident #01's Care Plan, reflected a Focus area was initiated on 4/22/2021 for resident having Cognitive Loss/Dementia. The goal was set to maintain current level of cognitive function by maximizing her involvement in daily decision making. 2. Record review of Resident #03's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of Chronic pain, Repeated falls, Diabetes Type II, Chronic Obstructive Pulmonary Disease (lung disease), and Bipolar disease. Record review of Resident #03's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the resident's cognitive ability was intact. Record review of Resident #03's Care Plan, reflected a Focus area was initiated 12/6/2024 for resident being at risk for infection related to Covid-19. Her goal was to remain free from serious infection. 3. Record review of Resident 13's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of Senile degeneration of brain, Anxiety disorder, Congestive Heart Failure, and Respiratory Failure. Record review of Resident 13's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 11, which indicated the resident's cognitive ability was moderately impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 13's Care Plan, reflected a Focus area was initiated on 1/22/2025 for resident having impaired cognitive function/dementia. Her goal was to improve current level of cognitive function. 4. Record review of Resident 51's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] with diagnoses of Colon Cancer, Open wounds, Hyponatremia (low sodium), and Congestive Heart Failure. Record review of Resident 51's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 11, which indicated the resident's cognitive ability was moderately impaired. Record review of Resident 51's Care Plan, reflected a Focus area was initiated on 12/5/2024 for resident requiring Hospice for terminal disease. The goal was to maintain dignity and keep pain free. Observation on 3/12/2025 at 8:43 AM, during medication pass, LVN-A removed a blood pressure cuff from the top of the medication cart and used it to take Resident #13's blood pressure. After taking the blood pressure, the cuff was replaced on the top of the medication cart without being sanitized. LVN-A proceeded to prepare Resident #13's medications on the cart then administered them to her. The blood pressure cuff remained on the top of the cart. Hand hygiene was done after leaving Resident #13's room Observation on 3/12/2025 at 9:08 AM, revealed LVN-A moved the medication cart to Resident #01's room and picked up the unclean blood pressure cuff. He proceeded to take Resident 01's blood pressure then returned the unclean blood pressure cuff to the top of the medication cart without sanitizing it. He then proceeded to prepare and administer the medications. LVN A performed hand hygiene but did not clean the medication cart surface or the blood pressure cuff on the medication cart. His hands had contact with both areas. Observation on 3/12/2025 at 9:17 AM, revealed LVN-A moved the medication cart to Resident #51's room and picked up the unclean blood pressure cuff. He proceeded to take Resident 51's blood pressure then returned the unclean blood pressure cuff to the medication cart without sanitizing it. He then proceeded to prepare the medications for Resident #51 and to administer the medications. When Resident 51's medications were completed he performed hand hygiene but did not clean the medication cart surface or the blood pressure cuff on the medication cart. His hands had contact with both areas. Observation on 3/12/2025 at 9:28 AM revealed LVN-A moved the medication cart to Resident #03's room The unclean blood pressure cuff remained on the medication cart. LVN-A then proceeded to prepare the medications for Resident #03 on the unclean medication cart surface and to administer the medications. When Resident 03's medications were complete he performed hand hygiene but did not clean the medication cart surface or the blood pressure cuff on the medication cart. In an interview with LVN-A on 03/12/25 at 09:39 AM, he stated that per policy he should have cleaned the blood pressure cuff between residents. He stated that equipment was cleaned to prevent cross contamination between residents. He also stated that the negative outcome to residents if equipment was not cleaned would be the spread of diseases and germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA-A on 3/13/2025 at 1:14 PM she stated, the policy for sanitizing between residents was to wear gloves and wipe the blood pressure cuff with sanitizing wipes. She stated this has to be done between every resident. She stated, it was important to sanitize equipment/work surfaces for infection control to prevent the spread of germs. She also stated that failure to sanitize could make the residents sick or potentially kill them if they can't fight off infections. In an interview with LVN-B on 3/13/2025 at 1:18 PM she stated, the policy was to sanitize hands and blood pressure cuffs between residents. She stated it is important to sanitized equipment and work surfaces for infection control on wounds, lesions or anything else that a resident could have. She further stated the negative outcome if equipment/work surfaces are not sanitized was germs could go from one resident to another and make them sick. In an interview with DON on 3/13/25 at 1:44 PM she stated, the policy for sanitizing equipment /work surfaces between residents was they should be wiped with sanitizing wipes between residents for any multiple use items. She stated it was important to sanitize equipment/work surfaces to prevent the spread of contaminates and the negative outcome to residents if this was not done is was you could spread contaminates from resident to resident and cause illnesses. In an interview with the ADM on 3/13/25 at 1:28 PM he stated, the policy for sanitizing equipment /work surfaces between residents was to use specific sanitizers between use. He stated it was important to sanitize equipment/work surfaces because if not you could potentially spread an infection to another resident and the negative outcome if equipment/work surfaces are not sanitized was that residents could get a virus, or an infection transmitted to them. A record review of the facility policy titled, Nursing Policy and Procedure-Infection Control-Cleaning and Disinfecting Resident Care Items and Equipment dated 10-2020, reflected the following: Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). Non-critical items (blood pressure cuffs) can be decontaminated where they are used.