STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676067	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mira Vista Court	7021 Bryant Irvin Rd Fort Worth, TX 76132

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property for 1 of 3 residents (Resident #1) reviewed for misappropriation of property. The facility failed to prevent the misappropriation of Resident #1's Hydrocodone 10/325's on 03/21/25 when LVN A diverted them. The noncompliance was identified as past noncompliance. The noncompliance began on 03/21/25 and ended on 03/22/25 . The facility had corrected the noncompliance before the abbreviated survey began. This failure could place residents at risk of misappropriation of property, missed medications and diminished quality of life. Findings included: Record review of Resident #1's Face Sheet, dated 06/05/25, reflected the resident was a [AGE] year-old male who originally admitted on [DATE] and readmitted on [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated 05/26/25, reflected he had a BIMS score of 15 which indicated no cognitive impairment. His active diagnoses included anxiety disorder (a group of mental health conditions characterized by excessive fear, worry, or dread that interferes with daily life), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities), and diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired). Record review of Resident #1's Physician's Order History for March 2025 reflected the following order: Hydrocodone-acetaminophen-Schedule II tablet; 10-325 mg; amt: 1-2 tablets; oral Special Instructions: Not to exceed > 3g of acetaminophen within 24 hrs from all sources. Hold for sedation. Every 6 Hours- PRN PRN 1, PRN 2, PRN 3, PRN 4 with an order start date of 03/06/25 and discontinue date of 06/04/25. Record review of Resident #1's Progress Notes for March 2025 reflected the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Labs reviewed by MD .Orders given to send resident to ER [sic] . on 03/20/25 1:25 PM written by the ADON -resident returned back to facility via non-emergent transportation . on 03/22/25 12:05 PM written by LVN B Record review of a provider investigation report, dated 03/27/25, reflected the following: Description of the Allegation: When [Resident #1] returned from the hospital on [DATE] it was discovered that his Hydrocodone 10/325 was missing .Investigation Summary: [Resident #1] received a new card of 60 Hydrocodone 10/325 on 03-16-25. The Hydrocodone was properly added to the Controlled Substance Card Count. [Resident #1] returned from the hospital on [DATE]. When [LVN B] went to administer a Hydrocodone 10/325 she could not find the count sheet nor the card holding the medication. [LVN B] called the pharmacy to confirm that the medication was delivered. 60 pills of Hydrocodone 10/325 was delivered on 03/16/25. The med room and other carts were searched. [LVN B] notified the [ADON] of the missing medication. [The ADON] notified the DON and Administrator. On 03-21-25 [LVN A] was working on the 100 hall where [Resident #1] resides. [LVN A] wasted a pitcher of water in the narcotic box on the 100 hall nurse med cart. [The DON] and the [MDS Coordinator] counted the narcotic box on 03-22-25. It appears that [LVN A] removed [Resident #1's] card of hydrocodone 10/325 and the count sheet from the cart at some point before the end of the shift on 03/22/25. [LVN A] had not returned the Administrators [sic] call after several attempts . Investigation Findings: Confirmed .Provider Action Taken Post-Investigation: [Resident #1's] Medication [sic] was replaced by the facility. Nurses were re educated [sic] on properly documenting on the Controlled Substance Card Count Sheet and proper counting of narcotic medication with the sign out sheets for the medication. Record review of an undated witness statement written by the DON reflected the following: On Friday, March 21,2025, [sic] I did a narcotic count for 100 hall med cart with [the MDS Coordinator]. We did a card and pill count after the nurse working the shift spilled the water pitcher into the narcotic drawer .We completed the count and did account for all of the cards with the matching sheet . Record review of an undated witness statement written by the MDS Coordinator reflected the following: On Friday, March 21, 2025, I did a narcotic count for hall 100 cart with [the DON]. We did a card and pill count after the water pitcher was spilt in the narcotic drawer .All the cards were accounted for with the matching sheets . Record review of the Controlled Substance Card Count Sheet for the 100 hall Nurse's medication cart reflected there were 19 cards on the cart on 03/20/25, 19 cards on 03/21/25, and 19 cards on 03/22/25. Interview on 06/05/25 at 8:45 AM with the Administrator revealed LVN A and LVN B were both agency nurses and after the incident on 03/21/25, he alerted their employer of his suspicions and had not planned to allow them to work at the facility again. Observation and interview on 06/05/25 at 9:10 AM revealed Resident #1 was in his bed resting. Resident #1 said he got his medications like he was supposed to and was not told his medications had been missing at one point. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review on 06/05/25 at 9:40 AM with LVN C revealed she was passing medications to residents. LVN C said she always counted both the cards in the narcotic box and the pills on each card and made sure that all the amounts were correct before starting or ending her shift. LVN C said if the card count or pill count was not right she would immediately inform management and would not take the cart keys from the other person. LVN C showed her narcotic count drawer and the card count and pill count matched what was on the sheets in the narcotic count book. Record review of the Controlled Substance Card Count Sheet reflected it had been filled out for each shift. Interview and record review on 06/05/25 at 9:50 AM with MA D revealed she was passing medications to residents. MA D said she always counted both the cards in the narcotic box and the pills on each card and made sure that all the amounts were correct before starting or ending her shift. MA D said if the card count or pill count was not right she would immediately inform management and would not take the cart keys from the other person. MA D showed her narcotic count drawer and the card count and pill count matched what was on the sheets in the narcotic count book. Record review of the Controlled Substance Card Count Sheet reflected it had been filled out for each shift. Interview and record review on 06/05/25 at 10:00 AM with MA E revealed she was passing medications to residents. MA E said she always counted both the cards in the narcotic box and the pills on each card and made sure that all the amounts were correct before starting or ending her shift. MA E said if the card count or pill count was not right she would immediately inform management and would not take the cart keys from the other person. MA E showed her narcotic count drawer and the card count and pill count matched what was on the sheets in the narcotic count book. Record review of the Controlled Substance Card Count Sheet reflected it had been filled out for each shift. Attempted phone interview on 06/05/25 at 10:39 AM with LVN A was unsuccessful as she did not answer or call back. Attempted phone interview on 06/05/25 at 10:42 AM with LVN B was unsuccessful as she did not answer or call back. Phone interview on 06/05/25 at 12:24 PM with RN F revealed she always checked the card and pill count on the cart before taking the keys. RN F said she recalled the card and pill count being correct when she counted with LVN A. RN F said she was not aware at the time of counting with LVN A that Resident #1's hydrocodone was missing. Interview on 06/05/25 at 11:39 AM with the MDS Coordinator revealed the DON called her over to witness the counting of the narcotic count on 03/21/25 . The MDS Coordinator said she and the DON counted all the cards on the cart and the pills in each card to make sure it was all correct. The MDS Coordinator said all the cards were there and so was Resident #1's hydrocodone cards as well. The MDS Coordinator said she was told that the nurse had spilled a pitcher of water in the narcotic drawer which was strange because she was not sure why someone would be pouring a pitcher of water into a cup over the open narcotic drawer. The MDS Coordinator said the nurse was from a staffing agency company and not an employee of the facility. The MDS Coordinator said she did not note anything missing at the time of the count on 03/21/25 and had no reason to believe anything was wrong. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/25 at 11:48 AM with the ADON revealed she got a call on 03/21/25 and was told that the agency nurse wasted water so the DON and someone else had counted the cart to make sure everything was still there. The ADON said from what she was told, the count was correct and everything was fine. The ADON said it was not until Saturday (03/22/25) when Resident #1 came back from the hospital and requested pain medications that it was noted the medication was missing. The ADON said Resident #1 was supposed to come back from the hospital on Friday (03/21/25) but they decided to keep him one more night. The ADON said Resident #1 always needed his pain medications since he had a lot of pain. The ADON said usually a resident's narcotics were removed from the cart when they were not in the building so they were left on the cart for that reason since he was coming back that day. The ADON said LVN B called the pharmacy because she thought maybe they were not delivered or something but they said the medication was delivered the week prior and there was no way he had already used them all in that time frame. The ADON said they went back and counted and both of Resident #1's hydrocodone cards were missing. The ADON said after that they did a full count of all narcotics in the facility and made sure nothing else was missing. The ADON said they also began to in-service the staff regarding making sure that all the cards and pills were counted each shift and each day. The ADON said on the card count sheet staff were to document any changes to the card count if something was discontinued, used up, or added so they could keep better track of them all. The ADON said she checks the carts on Thursdays of every week to ensure accuracy and nothing else came up missing. The ADON said she believed the cards went missing during LVN A's shift, possibly when the water was wasted in the drawer. Interview on 06/05/25 at 12:28 PM with the DON revealed LVN A was working on 03/21/25 and sometime in the afternoon she wasted water all over the cart. The DON said she went to the cart to check it and saw there was not that much water but assumed some of it was already cleaned up. The DON said she wondered why LVN A was pouring water into a cup over the open narcotic drawer but did not question LVN A about it. The DON said she and the MDS Coordinator went through the cart to check and make sure all cards and pills were accounted for and they were. The DON said the next day, Resident #1's hydrocodone cards were missing from the cart. The DON said she knew the cards were in the cart the day before because she saw them in there while doing her cart check count. The DON said she immediately started an investigation and looked everywhere else in the facility for them. The DON said she had her suspicion though that LVN A had taken them at that point. The DON said she tried calling both LVN A and LVN B and never got responses from them since they were both agency staff. The DON said the facility already had a procedure in place where not only did staff count the narcotic pills on each card against the narcotic count sheet but they also counted the amount of cards that were supposed to be on the cart. The DON said all staff were re-in-serviced on the procedure to ensure that they were following it so no more medications would come up missing. The DON said since the incident happened, the ADONs had been monitoring the medication carts three times per week to make sure they were all correct and that no medications were missing. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/25 at 1:17 PM with the Administrator revealed earlier in the day on 03/21/25 the DON was told that LVN A had spilled water in the narcotic drawer. The Administrator said the MDS Coordinator and the DON had counted all the cards and pills in the narcotic drawer after this happened to make sure nothing was missing. The Administrator said during that count nothing was missing and everything was accounted for. The Administrator said since the card count and the narcotic count sheets were all correct there was no reason to believe anything was missing. The Administrator said the next afternoon LVN B went to administer Resident #1 his norco medication and realized he did not have any. The Administrator said the DON had her suspicion about LVN A from the day before and the timing made sense that she was the one who took Resident #1's medications from the cart. The Administrator said he had called both LVN A and LVN B but since they were both from an agency they did not answer. The Administrator said he also submitted a police report regarding the taken medications . The Administrator said going forward the staff were re-educated on the facility's policy to count both the cards on the cart and the pills on each card against the sheets on the cart. The Administrator said the ADONs also go through the carts to ensure the counts were correct about once per week. The Administrator said no other medications had come up missing since this one incident. The Administrator said the purpose of staff following the policies and procedures to count the sheets was to make sure the counts were correct and no narcotic medications were missing. The Administrator said if staff were not doing this then residents could miss doses because their medications could come up missing. The Administrator said before the incident happened, the medication carts were checked only once per month for reconciliation. The Administrator said each nurse was responsible for checking the medication cart counts for each of their shifts. The Administrator said he expected staff to check their medication cart on each shift and if there was a discrepancy they should immediately report that to the DON. The Administrator said staff had been trained to check the medication cart count for accuracy on each shift before this incident happened. Record review of an in-service sheet, dated 03/22/25, reflected nurses and MAs were in-serviced regarding counting the narcotic cards and pills on their carts for each shift and if there was a discrepancy they were to immediately report that to the DON. Record review of a Police Report, dated 03/22/25, reflected one was submitted regarding the diverted medications. Record review of the facility's policy, revised 04/17/24, and titled Controlled Substances reflected: 5. If any discrepancy is found, nursing should check the patient's/resident's order sheets and medical record to see if a controlled substance has been administered and not recorded. Check previous recordings on the Controlled Substance Inventory Sheets for mistakes in arithmetic error in transferring numbers from one sheet to the next. A. If the cause of the discrepancy cannot be located and/or the count does not balance, the nurse must report the matter to the Director of Nursing/designee and generate the appropriate incident report. B. The DON/designee will then investigate to determine if a diversion has occurred.