

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Winnie L Ltc Partners Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2104 N Karnes Cameron, TX 76520	

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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141</p> <p>Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 4 residents (Resident #1) reviewed for significant medication errors.</p> <p>The facility failed to ensure Resident #1 received the medication Xarelto, an anticoagulant/blood thinner, which could have resulted in the resident developing or the worsening of a blood clot diagnosed soon after Resident #1 missed 24 doses of the medication from 05/15/24 to 06/08/24.</p> <p>This failure could place residents at risk of increased pain and health deterioration.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet revealed she was an [AGE] year-old admitted to the facility on [DATE] with diagnoses including chronic embolism (obstruction of an artery usually by a blood clot or air bubble) and thrombosis (blood clot) of unspecified deep veins of right lower extremity, peripheral vascular disease (a circulatory disease-causing blood vessels to narrow) and chronic pain.</p> <p>Record review of Resident #1's Admission MDS Assessment, dated 05/23/24, reflected Section C BIMS score was a 7, which indicated a severe cognitive impairment.</p> <p>Record review of Resident #1's Care Plan, undated, revealed a focus added on 6/13/24, for PVD with a history of chronic DVT. The goal is for Resident #1 to remain free from complications related to PVD. The interventions include give Xarelto for improved blood flow.</p> <p>Record review of Resident #1's Admission Packet from Resident #1's hospice agency dated 5/14/24, revealed medication orders included Xarelto 10mg tablet daily.</p> <p>Record review of Resident #1's, May 2024 MAR revealed Xarelto was not included in the medications scheduled to be given. Continued review of the June 2024 MAR indicated on June 9th the medication Xarelto was given for the first time by the facility.</p> <p>Record review of Resident #1's Physician telephone orders revealed an order dated 06/06/2024 for a doppler ultrasound of RLE to rule out DVT.</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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's progress notes dated 06/09/24 at 10:42 am, completed by LVN A reflected, : Resident continues with swelling to Rt leg thigh area Resident with routine care did require nurse and CNA to assist with turning in bed. Swelling to her Rt thigh is pitting edema +2 (a slight indention requiring 15 seconds or less to rebound when pressure is applied to skin), and tender to touch.</p> <p>(Hospice provider name) hospice to send tech out to facility for doppler to r/o (rule out) DVT/clot. Imaging test not performed at this time. Staff did encourage resident to limit getting out of bed. This nurse did speak with hospice on call (hospice nurse name) to inquire about imaging and to report change in the functional status,</p> <p>as resident has confusion and seems weaker with ADL's. This nurse asked about imaging as well. (Hospice nurse name) told this nurse that testing would be done on Monday 6/10/24 as they were waiting on machine to become available. She did instruct nurse to have facility to call back on tomorrow. (Hospice nurse name) also stated that a (hospice nurse name) hospice nurse would be out to see resident. Resident also reported that she did not receive a</p> <p>shower and request aide be sent out as well. (Hospice nurse name) assured this nurse that both would be out to facility today. Will continue to monitor.</p> <p>Continued review revealed a second note dated 06/09/24 at 4:20 pm, completed by LVN A reflected, Resident family in house at this time inquiring about resident condition as well as medication. This nurse did contact hospice and spoke again with (Hospice nurse's name) regarding medication list and was informed that Resident is to take Xarelto 10 mg at bedtime. This nurse did update facility med list adding to the MAR, medication is in house and to be given at bedtime. Resident did also complain to family that she had tingling in her fingertips. This nurse did inform family and resident that if she would like she could be sent to the ER department for evaluation and treatment d/t numbness and tingling in the hands as well as the swelling in the Rt leg. This nurse had informed hospice of this as well and was told, if she does go to hospital for work up and come back that is fine but if admitted to hospital, hospice services would be [sic] discontinued until discharged from hospital. Resident and family both declined ER visit stating, resident could wait for doppler and numbness and tingling in her hands was not new. Resident not sent to ER. v/s 123/74(blood pressure-62(pulse)-18 (respirations)-93%(oxygen saturation) on RA.</p> <p>Record review of Medication Error Report, dated 6/13/24, revealed the report documented the error as having occurred on 5/15/24. The report notes the DON missed the medication Xarelto on the orders during Resident #1's admission to the facility. The outcome to resident notes No harm to resident/DVT found after ultrasound.</p> <p>Interview on 7/1/24 at 12:27 pm with Resident#1's FM revealed they were visiting on 6/9/24 and asked LVN A about her medications. They were concerned she had the swelling to her leg indicating a blood clot like she had before. LVN A discovered Resident #1 had not been given her Xarelto. FM stated they were also concerned a doppler ordered by hospice on 6/06/24 not been completed. FM stated they met with the facility and hospice and the DON admitted there had been a medication error that she had misread the orders. The hospice agency reported they were having problems with their sonogram provider; it was not done until 6/11/24. LVN A had offered to send Resident #1 to the hospital on 6/9/24 but we had refused.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 7/1/24 at 2:18pm with LVN A revealed she was Resident #1's admitting nurse. She stated they were surprised to see her arrive as they had not known she was coming to be admitted . LVN A stated there was not a nurse with Resident #1 as there usually is with new admissions, and she was told one would be coming in later that day. LVN A stated the DON had gotten the orders from the hospice referral documents. LVN A stated a couple of weeks ago Resident #1's family was visiting and asked if she was still taking the Xarelto, when she went to check, she realized the medication had not been added at time of admission although it was on the orders. LVN A stated they also had some in her medication supply. She added it that day. LVN A stated the family was asking because a doppler had been ordered by hospice due to swelling to her leg. The doppler had not occurred yet so she called hospice and there was a delay with the doppler provider. LVN A stated she offered to send Resident #1 to the hospital to have it done but the family declined. The hospice nurse was informed of the error having occurred and the hospice physician was notified. When the doppler was done it confirmed that Resident #1 had a blood clot. Resident #1's Xarelto was increased temporarily by the hospice doctor. When asked, LVN A stated she knew it had been a significant error and had caused the resident to be unable to toilet herself as she had been, due to the pain in her leg.</p> <p>Interview on 7/1/24 at 2:48pm with Hospice CM RN B revealed she was not involved in Resident #1's initial admission. She stated she put the order in on 6/6/24 for the doppler sonogram after redness and swelling was noted to the resident's RLE. Once it was discovered Resident #1 was not receiving her Xarelto the Hospice Physician was notified of that error.</p> <p>Interview on 7/1/24 at 3:01pm with facility DON revealed that the facility was not expecting Resident #1 when she was admitted . Usually, a hospice nurse will accompany the resident but Resident #1 had an aide with her. DON stated she took off the orders from the documentation that arrived with Resident #1 because the Charge Nurse was busy. Usually, they will write the orders and the hospice nurse will check the orders to ensure they are correct, but that did not happen with Resident #1's admission. At the time she learned of the error she wrote out an error report including no harm to the residents because she did not yet know about the DVT. After becoming aware of the DVT she added the information.</p> <p>The DON stated they had a meeting with the hospice agency to let them know that a hospice nurse needs to come with a resident admitting to the facility to provide a second set of eyes checking the orders to catch mistakes at time of admission.</p> <p>Interview on 7/1/24 at 3:41pm with Adm revealed he was aware of the medication error involving Resident #1's Xarelto. He stated they usually do better than that. Administrator stated there was confusion in the process because the hospice nurse was a traveling nurse. They have since had an in-service regarding nursing ensuring that two nurses verify orders. He stated they also met with the hospice provider and let them know we wanted them to check that we have the orders right for their patient.</p> <p>Interview on 7/2/24 at 9:09 am with Hospice Phy revealed he was the primary doctor for Resident #1 while she has been with hospice. He works with her hospice provider. He stated the intent was for Resident #1 to routinely take a scheduled blood thinner as she has a history of developing blood clots. He stated missing the Xarelto probably did not cause her to develop the blood clot. He said she probably already had it and it worsened.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of policy titled Adverse Consequences and Medication Errors, dated 2001 revealed it included the following:</p> <ol style="list-style-type: none"> 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medication errors include: <ol style="list-style-type: none"> a. omission- a drug is ordered but not administered <p>And</p> 3. A significant medication-related error is defined as: <ol style="list-style-type: none"> a. Requiring medication discontinuation or dose modification. (Consult the current list of medications that should not be abruptly discontinued.) b. Requiring hospitalization , or extending a hospitalization . c. Resulting in a disability. d. Requiring treatment with a prescription medication. e. Resulting in cognitive deterioration or impairment. f. Life threatening. g. Resulting in death.