STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676121	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Tree Nursing and Rehabilitation Center	930 Roy Richard Dr Schertz, TX 78154

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, which are complete; and accurately documented for 1 of 4 residents (Resident #1) reviewed for documentation. Resident #'1's electronic medical record did not contain complete and accurate documentation that resident received the scheduled administration of oxycodone (a medication use to treat pain) on 6/10/24. This failure could result in residents' records not accurately documenting the administration of medications and could result in a decline in heath. The findings include: Record review of Resident #1's face sheet, dated 06/14/24, revealed a [AGE] year-old female resident who was admitted on [DATE] with diagnoses that included: end stage renal disease, anxiety, metabolic encephalopathy (brain disease), osteo (bone disease), HTN (hypertension). Resident was her own RP. Record review of Resident #1's admission MDS dated [DATE] revealed BIMS score was 11 (moderately impaired). Record review of Resident #1's CP, undated, read: The resident has a potential for uncontrolled pain and interventions included: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Record review of Resident#1's Physician' Orders, dated June 2024, revealed: resident was prescribed Oxycodone 30 mg every 8 hours for pain relief. Record review of Resident#1's MAR, dated June 2024, revealed, on 6/10/24 at 4:00 PM the resident was given oxycodone recorded by RN B. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 6/14/24 at 10:45 AM , Resident #1 was in her room speaking to a family member by telephone, sitting on a W/C with indwelling catheter, The resident stated she was prescribed Oxycodone for pain relief and had been taking the medication for the past [AGE] years. The resident could not remember whether she received her dose of oxycodone on 6/10/224 at 4:00 PM. During a telephone interview on 6/14/24 at 10:56 AM, Resident #1's family member stated that the resident was prescribed oxycodone for the past [AGE] years and he was not sure whether the prescribed oxycodone on 6/10/24 at 4:00 PM was administered to the resident by RN B. During an interview on 6/14/24 at 1:45 PM, RN A stated: she was the nurse on the 10PM-6 AM shift on 6/9/24. RN A stated that Resident #1 was not given the scheduled oxycodone on 6/10/24 at 4:00 PM by RN B. RNA stated she knew the medication was not given by RN A to the resident although the MAR June 2024 stated it was given because, the narcotic reconciliation count revealed that only two Oxycodone tablets were given on 6/10/24 and the 4:00 PM dose was not given. RN A stated she gave Resident #1 the doses scheduled for midnight at 11:30 PM. RN A stated there was no drug diversion involving RN B. RN A did not give an explanation as to why RN B documented giving Resident #1 the 4:00 PM dose of Oxycodone when in reality it was not dispensed. During a telephone interview on 6/14/24 at 3:09 PM with the DON present, RN B stated: I did not notice the narcotic as scheduled (oxycodone) was not given to her for the 8 hour scheduled time .it was my mistake . I did open the narcotic box in the CMA's medication cart. RN B decided not to give the scheduled 4:00 PM oxycodone to Resident #1 when she realized the mistake because it was too close to the next scheduled dose at midnight. RNB stated that she did not notify the DON of the mistake. RN B stated that physician's orders needed to be followed in reference to medication administration. RN B stated that she reported to RN A during shift change that she did not dispense to Resident #1 the scheduled oxycodone at 4:00 PM on 6/10/24. RN B stated the dose was missed because there was no CMA available and she forgot to take Resident #1's oxycodone from the CMA's medication cart. RN B did not give an explanation as to why she documented giving Resident #1 the 4:00 PM dose when in reality it was not administered. During an interview on 6/14/24 at 3:22 PM, the DON stated: when RN B moved Resident #1's medications from the CMA cart she did not move the narcotic (oxycodone) blister pack at 4:00 PM . The DON stated the timeline was that at the next scheduled dose at midnight the RN B realized she did not want to over medicate the resident because the resident was due for her next dose at midnight. The DON stated she heard on the telephone interview that RN B made a medication error and did not tell anyone for 8 hours until the shift ended for her. The DON stated the facility reconciled all narcotics on 6/10/24. The DON stated she did not have an explanation for the inaccurate June 2024 revealing that Resident #1 had been administered the 4:00 PM dose of oxycodone by RN B when in reality it was not administered. Observation on 6/14/24 at 3:50 PM, revealed LVN C counted the oxycodone pills prescribed to Resident #1. The Narcotic sheet read 62 pills remaining and the count revealed 62 oxycodone pills present. The count revealed that on 6/10/24 only two doses had been given instead of the three prescribed doses. [No drug diversion]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/14/24 at 3:52 PM, LVN C stated that Resident #1 was scheduled for oxycodone for pain every 8 hours and on 6/10/24 she only received 2 doses. LVN C stated that nursing staff had to follow MD orders and she could only guess that Resident #1 was asleep when the second 8 hour dose had to be administered. During a telephone interview on 6/14/24 at 4:05 PM, the Medical Director stated: Resident #1 was on scheduled oxycodone every 8 hours for pain. The MD stated that nursing staff needed to follow physician's orders and he was not informed on 6/10/24 or thereafter that Resident #1 missed a scheduled dose on 6/10/24. During an interview on 6/14/24 at 4;30 PM, the Administrator stated that her expectation was that nursing staff follow MD orders. She was not aware that Resident #1 missed a scheduled dose of oxycodone on 6/10/24 at 4:00 PM. Record review of facility's Physician's Orders policy undated read: ' Physician's monthly consolidated orders must be reviewed by a license nurse to ensure they reflect all current orders. Record review of facility's Medication Administration Procedures undated, read: .After the resident has been identified, administer the medication and immediately chart does administer on the medication administration record . Record review of the facility's Abuse/Neglect policy dated revised 3/29/18 read: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. .