

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Ussery Roan Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Tascosa Rd Amarillo, TX 79124	

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** 48161</p> <p>Based on observation, interview, and record review; the facility failed to ensure drugs were stored and labeled in accordance with currently accepted professional principles for 1 of 2 medication rooms.</p> <p>-The facility failed to store Hydrocodone-Acet 325mg properly by putting them with non-controlled discontinued medication in Medication room [ROOM NUMBER] and then later putting the medication in an ADON's office.</p> <p>This failure could result in a drug diversion placing residents at risk of not getting their medications as ordered.</p> <p>Findings included:</p> <p>In an observation on [DATE] at 5:00 AM, revealed Medication room [ROOM NUMBER] had a black plastic bin where non controlled discontinued medications were stored. The black bin had a slit and a hole on the lid and a combination lock on the bin.</p> <p>In an Interview on [DATE] at 5:00 AM, LVN A stated that the medications that were in the bin in the medication room were over the counter, non-controlled, discontinued medications. All controlled medications stayed in the medication cart until the Pharmacy Nurse retrieved the medication.</p> <p>In an interview with on [DATE] at 5:30 AM, LVN B stated that all narcotics stayed on the locked medication cart until the pharmacy nurse retrieved the medication. LVN B stated that non-narcotic drugs that were discontinued went into the black bin in the medication room.</p> <p>In an interview with on [DATE] at 5:40 AM, LVN C stated that she did not see RN D, or the Hospice Nurse put the Hydrocodone in the black bin but was told that was what occurred. LVN C stated that the Pharmacy Nurse was responsible for removing any narcotics from the medication cart.</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>In an interview with on [DATE] at 6:00 AM, ADON F stated that RN D took Hydrocodone 325 mg and disposed of it on [DATE] and put the medications in the black bin in Medication room [ROOM NUMBER]. ADON F stated that when RN D realized she made a mistake she called RN E the next morning and told her the mistake. RN E went to the bin and took the medication out of the bin and put it under ADON G's door until she could give it to the Pharmacy Nurse. The medication was in ADON G's office until the following day when ADON G took it to the Pharmacy Nurse. ADON F stated the negative outcome for medications not to be properly stored would be that a nurse could take them, and a resident could miss their medications.</p> <p>In an interview with the DON on [DATE] at 8:00 AM, The DON stated that it was a mistake by RN D putting the medication in the wrong bin. The DON stated the protocol for disposing of narcotics was to leave the medication in the medication cart until the Pharmacy Nurse and DON can pick them up and put them in the Pharmacy Nurse's office where she and the pharmacist would then dispose of the medication. The negative outcome for not following the protocol would be that the medication could get lost or stolen and residents would miss their medications.</p> <p>In an interview with RN D on [DATE] at 10:02 AM, RN D stated that the hospice nurse told her that when a resident expired the medications had to be disposed of immediately. RN D said after she and the hospice nurse put the hydrocodones in the bin in Medication room [ROOM NUMBER] she realized she made a mistake and called RN E and told her what she had done, and RN E said she would retrieve them and to not let anything like that happen again. RN D stated the negative outcome for putting medications in the wrong area would be that the medications could go missing and a resident would not have their medication.</p> <p>In an interview with RN E on [DATE] at 10:16 AM, RN E stated that she got the card of 30 hydrocodone out of the bin in Medication room [ROOM NUMBER] and put the card of hydrocodone under ADON G's door. RN E stated the negative outcome for not having the medication in a locked permanently fixed container would be that the medication could get stolen. RN E stated that the Pharmacy Nurse was responsible for getting the medications out of the medication cart and disposing of them.</p> <p>In an interview on [DATE] at 12:31 PM, the Hospice Nurse stated that she and RN D disposed of the medications in the bin in the medication room.</p> <p>In an interview on [DATE] at 12:41 PM, ADON G stated that RN E told her that she retrieved the medication out of the bin in Medication room [ROOM NUMBER]. ADON G stated that she told RN E to lock the medication up, and she didn't think that RN E would put them under her door. ADON G said she had been in health care for a long time, and she knew better than to have the narcotics put under her door. ADON G stated when she returned to work, she took the medications out of her office and gave them to the Pharmacy Nurse to lock them up in her office. ADON G stated that it was the Pharmacy Nurses responsibility to remove the narcotics from the cart and lock them up until the Pharmacy Nurse and Pharmacist disposed of the medications. ADON G stated that her office is kept locked when she is not in the office. ADON G stated the negative outcome for not having controlled drugs under secured conditions that the medications could get lost, disappear or someone could get their hands on them and if the drugs were stolen or lost a resident would need that medication and not have it.</p> <p>Record review of facility provided policy, titled Storage of Medications, revised [DATE], revealed the following:</p> <p>(continued on next page)</p>		

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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>.Schedule II-V controlled medication are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications.</p> <p>Record review of facility provided policy, title Discarding and Destroying Medications, no date, revealed the following:</p> <p>.All unused controlled substance should be maintained in a securely locked area with restricted access until disposed of.</p>