STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676187	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House of Marshall Health & Rehabilitation	5915 Elysian Fields Road Marshall, TX 75672

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, and dispensing of routine drugs and biologicals to meet the needs of each resident for 4 of 4 resident's reviewed for pharmacy services. (Resident's #1, #2, #3, and #4) 1. The facility failed to ensure LVN A reconciled Resident #1's hydrocodone-acetaminophen (controlled medication used for pain) on the individual control drug record after it was given on 01/28/25. 2. The facility failed to ensure LVN A reconciled Resident #2's hydrocodone-acetaminophen (controlled medication used for pain) on the individual control drug record after it was given on 01/28/25. 3. The facility failed to ensure LVN A reconciled Resident #3's Tylenol #3 (controlled medication used for pain) and lorazepam (controlled medication used for anxiety) on the MAR and the individual control drug record after it was given on 01/28/25. 4. The facility failed to ensure LVN A reconciled Resident #4's hydrocodone-acetaminophen (controlled medication used for pain) on the MAR and the individual control drug record after it was given on 01/28/25. These failures could place residents at risk for medication errors and loss of medications through drug diversion. The findings included: 1. Record review of the face sheet, dated 01/29/25, reflected Resident #1 was a [AGE] year-old male who initially admitted to the facility on [DATE] with a diagnosis of other specified injuries of lower back. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS assessment dated [DATE], reflected Resident #1 had clear speech and was understood by others. The MDS reflected Resident #1 was able to understand others. The MDS reflected Resident #1 had a BIMS score of 11, which indicated moderately impaired cognition. The MDS reflected Resident #1 had occasional, moderate pain which occasionally made it hard to sleep at night, participate in rehabilitation therapy, and limited his day-to-day activity during the 5-day look-back period. The MDS reflected Resident #1 received opioid (pain) medication during the look-back period. Record review of the comprehensive care plan, last reviewed on 11/06/24, reflected Resident #1 had chronic pain related to multiple old injuries and refused to be evaluated for pain management. The interventions included: monitor/record/report to nurse resident complaints of pain or requests for pain treatment. Record review of the order summary report, dated 01/29/25, reflected Resident #1 had an order, which started on 01/28/25, for hydrocodone-acetaminophen (controlled medication used for pain) 10-325 mg - give 1 tablet by mouth every 6 hours as needed for pain, may have medication between 10 PM - 11 PM on night dose. Record review of the MAR, dated January 2025, reflected Resident #1 received hydrocodone-acetaminophen (controlled medication used for pain) 10-325 mg on 01/28/25 at 6:45 AM with effective results. 2. Record review of the face sheet, dated 01/29/25, reflected Resident #2 was an [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of dementia (memory loss), a broken left femur (leg), and broken lumber vertebra (lower back). Record review of the quarterly MDS assessment, dated 01/03/25, reflected Resident #2 had unclear speech and was sometimes understood by others. The MDS reflected Resident #2 was sometimes able to understand others. The MDS reflected Resident #2 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS reflected Resident #2 had frequent pain that rarely made it hard to sleep at night, occasionally limited participate in rehabilitation therapy, and occasionally limited day-to-day activities during the 5-day look-back period. The MDS reflected Resident #2 rated her worse pain during the look-back period at a 5, which indicated moderate to severe pain. The MDS reflected Resident #2 received opioid (pain) medication during the look-back period. Record review of the comprehensive care plan, last reviewed on 01/08/25, reflected Resident #2 had chronic pain related to diabetic neuropathy (numbness or tingling in hands or feet). The interventions included: monitor/record/report to nurse resident complaints of pain or requests for pain treatment. Record review of the order summary report, dated 01/29/25, reflected Resident #2 had an order, which started on 04/27/24, for hydrocodone-acetaminophen (controlled medication used for pain) 7.5-325mg - give one tablet by mouth two times a day for pain. Record review of the MAR, dated January 2025, reflected Resident #2 received hydrocodone-acetaminophen (controlled medication used for pain) 7.5-325 mg on 01/28/25 at 9 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of the face sheet, dated 01/29/25, reflected Resident #3 was a [AGE] year-old male who initially admitted to the facility on [DATE] with a diagnosis of chronic pain and anxiety disorder. Record review of the quarterly MDS assessment, dated 11/29/24, reflected Resident #3 had no speech but was sometimes understood by others. The MDS reflected Resident #3 was sometimes able to understand others. The MDS reflected Resident #3 had a BIMS score of 0, which indicated severe cognitive impairment. The MDS reflected Resident #3 had an active diagnosis of chronic pain and anxiety. The MDS reflected Resident #3 had pain during the look-back period and rated it at 5, which indicated moderate-severe pain. The MDS reflected Resident #3 was unable to answer all the pain interview questions so a staff assessment was conducted. The MDS reflected Resident #3 had vocal complaints of pain 3-4 days of the 5-day look-back period. The MDS reflected Resident #3 received opioid (pain) medication during the look-back period. The MDS reflected Resident #3 did not receive an antianxiety medication during the look-back period. Record review of the comprehensive care plan, last reviewed 01/14/25, reflected Resident #3 had pain. The interventions included: monitor/record/report to nurse resident complaints of pain or requests for pain treatment. The care plan further reflected Resident #3 had a history of anxiety. The interventions included: administer medication per orders. Record review of the order summary report, dated 01/29/25, reflected Resident #3 had the following orders: 1. Tylenol #3 (controlled medication used for pain) 300-30 mg - give 1 tablet via gastrostomy tube two times a day for pain, which started on 09/07/24. 2. lorazepam (controlled medication given for anxiety) 0.5mg - give 1 tablet via gastrostomy tube every 6 hours as needed for pain, which started on 01/18/25. Record review of the MAR, dated January 2025, reflected Resident #3 received Tylenol #3 (controlled medication used for pain) 300-30 mg on 01/28/25 in the AM. The MAR further reflected Resident #3's lorazepam (controlled medication used for anxiety) 0.5 mg was blank for 01/28/25, which indicated the medication was not signed out as given. 4. Record review of the face sheet, dated 01/29/25, reflected Resident #4 was a [AGE] year-old male who initially admitted to the facility on [DATE] with a diagnosis of broken lumber vertebra (lower back). Record review of the admission MDS assessment, dated 10/14/24, reflected Resident #4 had clear speech and was understood by others. The MDS reflected Resident #4 was able to understand others. The MDS reflected Resident #4 had a BIMS score of 11, which indicated moderately impaired cognition. The MDS reflected Resident #4 had occasional, moderate pain which occasionally made it hard to sleep at night, limited participation with rehabilitation therapy, and limited day-to-day activities during the 5-day look-back period. The MDS reflected Resident #4 received opioid (pain) medication during the look-back period. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the comprehensive care plan, last reviewed 01/14/25, reflected Resident #4 had the potential for uncontrolled pain. The interventions included: monitor/record/report to nurse resident complaints of pain or requests for pain treatment. Record review of the order summary report, dated 01/29/25, reflected Resident #4 had an order, which started on 12/10/24, for hydrocodone-acetaminophen (controlled medication used for pain) 7.5-325 mg - give one tablet by mouth every 6 hours as needed for pain. Record review of the MAR, dated January 2025, reflected Resident #4's hydrocodone-acetaminophen (controlled medication used for pain) 7.5 mg was blank, which indicated the medication was not signed out as given on the 6 am to 6 pm shift on 01/28/25. During an observation and record review on 01/28/25 beginning at 4:52 PM, the ADON obtained the 400 hall medication cart and keys to reconcile narcotic (controlled) medications with the surveyor. During the narcotic (controlled) medication reconciliation: 1. Resident #1's hydrocodone-acetaminophen 10-325 mg medication cards were attached with a rubber band. Resident #1's hydrocodone-acetaminophen mediation cards had 27 pills on one card, and 60 pills on the other card for a total of 87 pills. The individual control drug record for the hydrocodone-acetaminophen 10-325 mg medication reflected Resident #1 had 88 pills left. The count was off by 1 pill. 2. Resident #2's hydrocodone-acetaminophen 7.5-325 mg medication card was empty. The individual control drug record for the hydrocodone-acetaminophen 7.5-325 mg medication reflected Resident #2 had 1 pill left. The count was off by 1 pill. 3. Resident #3's Tylenol #3 300-30 mg medication card had 23 pills. The individual control drug record for the Tylenol #3 reflected Resident #3 had 24 pills left. The count was off by 1 pill. 4. Resident #3 had two medication cards for the lorazepam 0.5 mg in the lock box. One card had 29 pills and the next card had 30 pills for a total amount of 59 pills. The individual control drug record for the lorazepam 0. 5 mg medication reflected Resident #3 had 60 pills left. The count was off by 1 pill. 5. Resident #4's hydrocodone-acetaminophen 7.5-325 mg medication card had 8 pills. The individual control drug record for the hydrocodone-acetaminophen 7.5-325 mg reflected Resident #4 had 9 pills left. The count was off by 1 pill. During an interview on 01/28/25 beginning at 5:14 PM, ADON B stated controlled medication should have been signed out as it was given. ADON B stated she was going to perform in-service training with the nurses. During an interview on 01/28/25 beginning at 5:23 PM, LVN A stated he administered all the missing medications to the residents. LVN A stated he believed when he signed out the medication in the computer that was sufficient while passing his medication. LVN A stated he was going to sign the paper record at a later time. LVN A stated he realized he made a mistake. LVN A stated it placed the residents at risk for a medication error and drug diversion, especially if he had to leave unexpectedly and the count was off. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/29/25 beginning at 7:36 AM, ADON B stated in-service training was performed on 01/28/25 with LVN A. ADON B stated Resident's #1, #2, #3, and #4 were assessed for pain with no indicators of pain noted. ADON B stated she expected the nursing staff to ensure controlled medications were signed out as it was given. ADON B stated it should have been signed out in the MAR and the individual drug control record. ADON B stated it was important to ensure controlled medication was signed out as it was given because anything could have happened. ADON B stated it placed the residents at risk for medication errors and drug diversion. During an interview on 01/29/25 beginning at 7:46 AM, the Administrator stated he expected controlled medications to be signed out when they were given. The Administrator stated the controlled medications should have been signed out in the MAR and on the paper form. The Administrator stated nursing management and pharmacy staff were responsible for monitoring to ensure medications were signed out as they were given. The Administrator stated it was important to ensure medications were signed out as given to prevent a medication error or a drug diversion. Record review of the Medication Administration Procedures policy, revised 10/25/17, reflected .administer the medication and immediately cart doses administered on the medication administration record .it is recommended that medication be charted immediately after administration, but if facility policy permits, medications may be charted immediately before . Record review of the Storage and Documentation of Controlled Medications policy, year dated 2003, reflected Disposition of controlled substances is maintained on the sheet supplied by the Pharmacy with each controlled substance .entries are to be made in pen each time a controlled substance is used .the nurse administering the medication will record the following information: date and time drug is administered, amount of drug administered, remaining balance of drug, and signature of nurse administering drug .