

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Granite Mesa Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Max Copeland Dr Marble Falls, TX 78654	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49410</p> <p>Based on interview and record review, the facility failed to ensure each resident had the right to be free from misappropriation of property for 3 of 6 residents (Resident #1, Resident #2 and Resident #3) reviewed for misappropriation of property.</p> <p>The facility failed to prevent the misappropriation of Residents #1, #2, and #3's hydrocodone/APAP tablets (a schedule II controlled opioid medication used to treat pain).</p> <p>This failure placed residents at risk for not receiving prescribed medications.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's AR, dated 5/4/2022, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. She was diagnosed with Dementia (the loss of cognitive functioning), cognitive communication deficit (disorder that could cause trouble reasoning and making decisions while communicating) and muscle weakness.</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 09/16/2024, reflected based on Section C: Cognitive Patterns, the resident had no cognitive impairment. Based on Section J: Health Conditions, the resident received scheduled pain medication regimen. Based on Section N: Medications, the resident received antidepressant and opioid medications.</p> <p>Record review of Resident #1's CP reflected a Focused area, initiated on 3/29/2023, evidenced for chronic pain. The goal initiated on 3/29/2023, was that the resident would be free of any discomfort or adverse side effects from pain or medication through the review date. The Intervention, initiated 3/29/2023, was that staff was supposed to administer medications as ordered.</p> <p>Record review of Resident #1's Order Summary Report, viewed on 9/26/2024, reflected the resident was ordered 1 hydrocodone-acetaminophen tablet, 5-325 mg by mouth three times a day, for pain; Ordered 07/10/2024.</p> <p>2. Record review of Resident #2's AR, dated 9/26/2024, reflected an [AGE] year-old male, who was admitted to the facility on [DATE]. He was diagnosed with disturbance, unilateral primary osteoarthritis left arm (joint condition that primarily affects one side of the body), and Muscle Wasting and Atrophy (which was a condition that caused muscle decrease in size and ability).</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's Quarterly MDS, dated [DATE] reflected Section C., Cognitive Patterns: Resident had a BIMS Score of 06. A BIMS score of 06 indicated the resident had moderate cognitive impairment. Section N., Medications: Resident received antidepressants and opioid medications.</p> <p>Record review of Resident #2's CP reflected a [Focused] area, initiated on 12/31/2023 evidenced resident was on pain medication therapy. The [Goal,] initiated on 12/31/2023, was that resident will be free of any discomfort or adverse side effects from pain medication through the review date. The [Intervention,] initiated 12/31/2023, was to administer medications as ordered.</p> <p>Record review of Resident #2's Order Summary Report, viewed 09/26/2024, reflected the resident was ordered 2 (two) hydrocodone-acetaminophen 10-325 mg tablet by mouth every 6 hours as needed; ordered 07/05/2024.</p> <p>3. Record review of Resident #3's AR, dated 09/26/2024, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. She was diagnosed with surgical aftercare, osteoporosis (a condition in which bones become weak and brittle), and chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems).</p> <p>Record review of Resident #3's Quarterly MDS, dated [DATE] reflected Section C., Cognitive Patterns: Resident had a BIMS Score of 07. A BIMS score of 07 indicated the resident had moderate cognitive impairment. Section N., Medications: Resident received antidepressants and opioid medications.</p> <p>Record review of Resident #3's CP reflected [Focused] area, initiated on 09/17/2022 evidenced resident has chronic pain. The [Goal] initiated on 09/17/2022 was that the resident will not have an interruption in normal activities due to pain through the review date.</p> <p>Record review of Resident #3's Order Summary Report, viewed 09/26/2024, reflected the resident was ordered 2 (two) hydrocodone-acetaminophen 10-325 mg tablet by mouth every 6 hours; ordered 06/17/2024.</p> <p>Record review of the facility's PIR, dated 07/25/2024, indicated an allegation of drug diversion occurred on 07/24/2024; reported to the state offices on 07/24/2024. The alleged victims were Resident #1, Resident #2 and Resident #3 who all allegedly had hydrocodone-acetaminophen misappropriated. There was no alleged perpetrator listed on the PIR.</p> <p>RR of packing slip proof for Resident #1 revealed that hydrocodone-acetaminophen 5-325 mg 90 tablets was delivered to the facility on [DATE].</p> <p>RR of packing slip proof for Resident #2 revealed that hydrocodone-acetaminophen 10-325 mg 172 tablets was delivered to the facility on [DATE].</p> <p>RR of packing slip proof for Resident #3 revealed that hydrocodone-acetaminophen 5-325 mg 176 tablets was delivered to the facility on [DATE].</p> <p>RR of medication administration log inside the PIR for Resident #1 revealed that on 07/11/2024 at 1:00 PM, the resident had 6 hydrocodone-acetaminophen 5-325 mg tablets left. This document was folded up and found in the locked shred bin. Another log for this same medication revealed on 07/11/2024 at 1PM, the top of the log specified there were 27 tablets.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>RR of medication administration log for Resident #2 revealed that on 07/22/2024 at 11PM the resident had zero hydrocodone-acetaminophen 10-325 mg tablets left for one blister pack.</p> <p>RR of medication administration log for Resident #3 revealed that on 07/11/2024 at 6AM, the resident had 8 hydrocodone-acetaminophen 10-325 mg tablets left. This document was folded up and found in the locked shred bin.</p> <p>RR of MT A's employee file revealed that MT A's date of hire was 03/30/2012 and her employment was terminated on 07/26/2024. MT A had received training on Abuse, Neglect and Exploitation on 09/03/2023. MT A had also received training on Medication Administration 04/28/2019, Avoiding Medication Related Problems 03/19/2022, Drug Diversion 09/11/2023, Drug Diversion in Healthcare 10/11/2021, and Protecting Resident's Right in Nursing Facilities 08/14/2020. MT A's employee file also revealed criminal background checks and the national registry had been checked which had no results.</p> <p>RR of MT A's schedule dated Thursday 07/11/2024 revealed that MT A was scheduled to work on the 100 hall. MT A's signature matched with the signature on the medication administration sheet for Resident #1, Resident #2 and Resident #3.</p> <p>An interview with the DON on 09/26/2024 at 3:30 PM revealed that the DON had initiated a drug diversion investigation that was discovered on 07/24/2024. The DON stated that they were alerted that Resident #2 needed a new order for his hydrocodone-acetaminophen 10-325 mg. The DON stated that they reached out to, the resident's physician who stated that the resident should have had plenty of that medication left. The DON stated this opened an investigation. The DON stated that they found the tops of the medication blister packs in the trash but could not locate the medication administration chart log. The DON had an outside source unlock the shred bin to check for the documents. The DON stated that she had found two resident medication administration chart logs folded up inside the shred bin. The DON stated this was unusual as the documents should be provided to records for proper discarding of resident information. The DON stated she found which staff member had access to these medications, as the medication administration charts showed numbers of medications still being left on the blister pack. Resident #2 was missing two more medication administration logs. The DON stated she had narrowed down who was working on the hall with Resident #1, Resident #2 and Resident #3. She stated all resided on the 100 hall and was being provided medications by one staff member. The DON stated she found new medication administration logs started for each resident in the medication cart. The DON stated during her investigation she asked MT A why the documents were in the shred bin and where the missing medication was. The DON stated that MT A said that based off of evidence presented to her, it looked like MT A had taken the medication. When the DON asked MT A if she had taken the medications, MT A did not respond. The DON stated MT A was placed on suspension pending the investigation, which resulted in MT A's employment at the facility being terminated.</p> <p>An interview was completed with the ADM on 09/26/2024 at 05:30 PM revealed that he had expectations for staff to follow the policy regarding medication administration otherwise disciplinary action would occur. ADM reported that the DON would be notified of a possible drug diversion due to ADM not being a nurse. ADM reported that the facility provided trainings for resident rights and misappropriation of property, over Relias. ADM reported that a possible negative outcome of a resident not being provided their medication was that it could be life threatening. He stated if the medicine was for pain, it could result in the resident being in constant pain.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with RP on 09/26/2024 at 06:15 PM over the telephone. RP reported that he was a geriatric doctor who has provided diagnoses and dosage of medications to residents at the facility. RP reported that he was informed of the drug diversion investigation. He stated the facility had called him and let him know that Resident #2 needed more hydrocodone-acetaminophen 10-325 mg tablets. He stated that he told the facility that he would not refill the medication as the facility should have had enough. He stated that he told the facility to investigate for a possible diversion. He said that the facility suspended the employee and kept him informed about what was going on in the investigation.</p> <p>Interview was attempted with MT A on 09/26/2024 at 06:40 PM over the telephone. MT A did not answer the phone call.</p> <p>Record review of the facility's policy Abuse Prevention of and Prohibition Against, dated 11/2017, revealed misappropriation of property meant the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. According to the document, the steps that are to be taken for potential misappropriation of property is to:</p> <ol style="list-style-type: none"> 1. Interview the person who is reporting the incident 2. Interview the residents 3. Interview with any witnesses to the incident, including the alleged perpetrator, as appropriate 4. A review of the resident's medical record 5. An interview with staff members on all shifts who may have information regarding the alleged incident. <p>The facility would complete the following regarding reporting/response:</p> <ol style="list-style-type: none"> 1. All allegations of abuse, neglect, misappropriation of resident's property or exploitation will be reported immediately to the administrator. 2. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate state or federal agencies in the applicable timeframes, as per this policy and applicable regulations. 3. The facility will ensure that all individuals who are involved in the reporting or investigation process are free from retaliation or reprisal. 4. Post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint. 5. At the conclusion of the investigation, the facility will take action, as necessary in light of the information gathered, which may include but is not limited to <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - If the allegations are substantiated, analyzing the occurrence to determine why abuse, neglect, misappropriation of resident's property, or exploitation occurred, and determining what changes are needed to prevent further occurrences - Defining how care provision will be changed and/or improved to protect residents receiving services if appropriate. - Training all staff on changes made and demonstration of staff competency after training was implemented - Identifying staff responsible for the implementation of corrective action - The expected date for implementation and - Identifying staff responsible for monitoring the implementation of the plan <p>6. A summary of investigative findings will be reported to the Quality Assessment and Assurance Committee for coordination with the Quality Assurance and Performance Improvement Program.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49410</p> <p>Based on observations, interviews, and record review, the facility failed to ensure each resident had the right to be free from misappropriation of property for 3 of 6 residents (Resident #1, Resident #2 and Resident #3) reviewed for pharmacy services.</p> <p>The facility failed to follow their procedures that prevent drug diversions.</p> <p>This failure placed residents at risk for not receiving prescribed medications.</p> <p>Findings included:</p> <p>Record review of Resident #1's AR, dated 5/4/2022, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. She was diagnosed with Dementia (the loss of cognitive functioning), cognitive communication deficit (disorder that could cause trouble reasoning and making decisions while communicating) and muscle weakness.</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Section C., Cognitive Patterns: Resident had no cognitive impairment. Section J: Health Condition; Resident received scheduled pain medication regimen. Section N., Medications: Resident received antidepressant and opioid medications.</p> <p>Record review of Resident #1's CP reflected a focused area, initiated on 3/29/2023, evidenced for chronic pain. The goal initiated on 3/29/2023, was that resident will be free of any discomfort or adverse side effects from pain or medication through the review date. The Intervention initiated 3/29/2023, was that staff was supposed to administer medications as ordered.</p> <p>Record review of Resident #1's Order Summary Report, viewed on 9/26/2024, reflected the resident was ordered 1 (one) hydrocodone-acetaminophen tablet, 5-325 mg by mouth three times a day, for pain; Ordered 07/10/2024.</p> <p>Record review of Resident #2's AR, dated 9/26/2024, reflected an [AGE] year-old male, who was admitted to the facility on [DATE]. He was diagnosed with disturbance, unilateral primary osteoarthritis left arm (joint condition that primarily affects one side of the body), and Muscle Wasting and Atrophy (which was a condition that caused muscle decrease in size and ability).</p> <p>Record review of Resident #2's Quarterly MDS, dated [DATE] reflected Section C., Cognitive Patterns: Resident had a BIMS Score of 06. A BIMS score of 06 indicated the resident had moderate cognitive impairment. Section N., Medications: Resident received antidepressants and opioid medications.</p> <p>Record review of Resident #2's CP reflected a focused area, initiated on 12/31/2023 evidenced resident was on pain medication therapy. The goal initiated on 12/31/2023, was that resident will be free of any discomfort or adverse side effects from pain medication through the review date. The Intervention initiated 12/31/2023, was to administer medications as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's Order Summary Report, viewed 09/26/2024, reflected the resident was ordered 2 (two) hydrocodone-acetaminophen 10-325 mg tablet by mouth every 6 hours as needed; ordered 07/05/2024.</p> <p>Record review of Resident #3's AR, dated 09/26/2024, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. She was diagnosed with surgical aftercare, osteoporosis (a condition in which bones become weak and brittle), and chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems).</p> <p>Record review of Resident #3's Quarterly MDS, dated [DATE] reflected Section C., Cognitive Patterns: Resident had a BIMS Score of 07. A BIMS score of 07 indicated the resident had moderate cognitive impairment. Section N., Medications: Resident received antidepressants and opioid medications.</p> <p>Record review of Resident #3's CP reflected focused area, initiated on 09/17/2022 evidenced resident has chronic pain. The goal initiated on 09/17/2022 was that the resident will not have an interruption in normal activities due to pain through the review date.</p> <p>Record review of Resident #3's Order Summary Report, viewed 09/26/2024, reflected the resident was ordered 2 (two) hydrocodone-acetaminophen 10-325 mg tablet by mouth every 6 hours; ordered 06/17/2024.</p> <p>Record review of the facility's PIR, dated 07/25/2024, indicated an allegation of drug diversion occurred on 07/24/2024; reported to the state offices on 07/24/2024. The alleged victims were Resident #1, Resident #2 and Resident #3 who all allegedly had hydrocodone-acetaminophen misappropriated. There was no alleged perpetrator listed on the PIR.</p> <p>RR of packing slip proof for Resident #1 revealed that hydrocodone-acetaminophen 5-325 mg 90 tablets was delivered to the facility on [DATE].</p> <p>RR of packing slip proof for Resident #2 revealed that hydrocodone-acetaminophen 10-325 mg 172 tablets was delivered to the facility on [DATE].</p> <p>RR of packing slip proof for Resident #3 revealed that hydrocodone-acetaminophen 5-325 mg 176 tablets was delivered to the facility on [DATE].</p> <p>RR of medication administration log for Resident #1 revealed that on 07/11/2024 at 1PM the resident had 6 hydrocodone-acetaminophen 5-325 mg tablets left. This document was folded up and found in the locked shred bin. Another log for this same medication revealed on 07/11/2024 at 1PM the top of the log revealed there were 27 tablets.</p> <p>RR of medication administration log for Resident #2 revealed that on 07/22/2024 at 11PM the resident had zero hydrocodone-acetaminophen 10-325 mg tablets left for one blister pack. Resident #2 was missing two more medication administration logs.</p> <p>RR of medication administration log for Resident #3 revealed that on 07/11/2024 at 6AM the resident had 8 hydrocodone-acetaminophen 10-325 mg tablets left. This document was folded up and found in the locked shred bin.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>RR of MT A's employee file revealed that MT A's date of hire was 03/30/2012 and her employment was terminated on 07/26/2024. had received training on Abuse, Neglect and Exploitation on 09/03/2023. MT A had also received training on Medication Administration 04/28/2019, Avoiding Medication Related Problems 03/19/2022, Drug Diversion 09/11/2023, Drug Diversion in Healthcare 10/11/2021, and Protecting Resident's Right in Nursing Facilities 08/14/2020. These trainings were completed by MT A. MT A's employee file also revealed criminal background checks and the national registry had been checked which had no results.</p> <p>RR of employee schedule dated Thursday 07/11/2024 it revealed that MT A was scheduled to work on the 100 hall, which also revealed MT A's signature matched with the medication administration sheet.</p> <p>Interview on 09/26/2024 at 02:20PM with LVN A revealed at shift change, the two workers assigned to the medication cart will do a drug count and confirm with each other.</p> <p>Interview on 09/26/2024 at 3:00PM with LVN B revealed during shift change the oncoming nurse would typically stand at the medication in the cart and the off going nurse would be at the book and they will confirm he numbers in the cart and the book.</p> <p>During an interview with the DON on 09/26/2024 at 3:30PM revealed that DON had initiated a drug diversion investigation that was discovered on 07/24/2024. The DON stated that they were alerted of Resident #2 needed a new order for his hydrocodone-acetaminophen 10-325 mg. The DON stated that they reached out to, the resident provider, who stated that the resident should have plenty of that medication left. The DON stated this opened an investigation. The DON stated that they found the tops of the medication blister packs in the trash but could not locate the medication administration chart log. The DON had an outside source unlock the shred bin to check for the documents. The DON stated that she had found two resident medication administration chart logs folded up inside the shred bin. The DON stated this was unusual as the documents should be provided to records for proper discarding of resident information. The DON stated she found which staff member had access to these medications, as the medication administration charts showed numbers of medications still being left on the blister pack. The DON stated she had narrowed down who was working on the hall as Resident #1, Resident #2 and Resident #3 all resided on the 100 hall and was being provided medications by one staff member. The DON stated she found new medication administration charts started for each resident in the medication cart. The DON stated during her investigation she asked MT A why the documents were in the shred bin and where the missing medication was. The DON stated that MT A stated it looked like MT A had taken the medication. When the DON asked MT A if she had taken the medications in which MT A did not respond. The DON stated MT A was placed on suspension pending the investigation, which resulted in MT A's employment at the facility being terminated. The DON stated that staff are no longer able to remove medications from the carts, even if the blister pack is empty.</p> <p>An interview was completed with ADM on 09/26/2024 at 05:30PM. ADM revealed that he had expectations for staff to follow the policy regarding medication administration otherwise disciplinary action would occur. ADM reported that the DON would be notified of a possible drug diversion due to ADM not being a nurse. ADM reported that the facility has provided trainings over Relias. ADM reported that a possible negative outcome of a resident did not provide their medication was that it could be life threatening, if the medicine was for a pain medication it could result in the resident being in constant pain.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview completed with Consultant Pharmacist on 09/26/2024 at 6:00PM over the telephone. reported that the facility had reported to her about the drug diversion investigation the last time she entered the facility. She stated that she ensured that the processes were followed as far as corrective actions that were made. She stated that the facility notified her of the drug diversion that had been investigated. She stated that the facility's process was reviewed and found no discrepancies.</p> <p>Interview with RP on 09/26/2024 at 06:15PM over the telephone. RP reported that he was a geriatric doctor who has provided diagnosis and dosage to residents at the facility. RP reported that he was informed of the drug diversion investigation. He stated the facility had called him and let him know that Resident #2 needed more hydrocodone-acetaminophen 10-325 mg tablets. He stated that he told the facility that he would not refill the medication as the facility should have had enough. He stated that he told the facility to investigate for a possible diversion. He said that the facility suspended the employee and kept him informed about what was going on in the investigation.</p> <p>Interview was attempted with MT A on 09/26/2024 at 06:40PM over the telephone. MT A did not answer the phone call.</p>