| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676230 | A. Building<br>B. Wing | 07/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Copperfield Healthcare and Rehabilitation | 7107 Queenston Blvd<br>Houston, TX 77095 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215<br><br>Based on interview and record review, the facility failed to develop a comprehensive person-centered admission baseline care plan within 48 hours of admission for 1 of 6 residents (Resident #22) reviewed for baseline care plans in that:<br><br>- Resident #22 did not have a baseline care plan that addressed his diagnosis of pneumonia completed within 48 hours of admission.<br><br>This failure placed newly admitted residents at risk of not receiving services to meet their needs.<br><br>Findings Include:<br><br>Record review of Resident #22's Face sheet revealed a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses, Pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), chronic diastolic heart failure (a condition in which your heart's main pumping chamber becomes stiff and unable to fill properly), obstructive hydrocephalus (occurs when the flow of CSF is blocked along one or more of the narrow passages connecting the ventricles), and hyperlipidemia (a condition in which there are high levels of fat particles in the blood).<br><br>Record review on Resident #22's Admission MDS assessment dated [DATE], revealed he had a BIMS score of 0 out of 15, indicating she had severe cognitive impairments. Further record review revealed he was dependent for toileting, shower/bath, upper body and lower body dressing and personal hygiene. He required supervision or touching assistance for eating. He did not walk and used a wheelchair for mobility. He was dependent on chair to bed transfer and needed substantial assistance to roll left and right.<br><br>Record review on of Resident #22's Baseline Plan of Care dated Admission: 6/15/2024, Focus, Goal and interventions were blank. There was no initiated date or revision date for pneumonia.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #22's Progress Notes dated 06/19/2024 written by APRN/FNP revealed; Room: 313-B History, Code Status: Full Scope of Treatment, Visit Type: SNF, F/U Problem, CC/HPI: Patient hospitalized on [DATE] and treated for Pulmonary Edema, Pneumonia, Sepsis, UTI, AKI d/t Metabolic Acidosis, and acute on chronic CHF. He was readmitted to this SNF on 6/16/24 with new order for Cefadroxil every 12 hours until 6/30/24. ER of abdomen and pelvis during hospitalization showed bilateral staghorn renal calculi. He was referred to Urologist Dr. Sathyamurthy that recommended observation at that time and to return to clinic in 2 to 3 weeks after DC from hospital to review imaging and discuss surgical planning. Patient has stage 4 PU to sacrum and had recent Osteomyelitis and has MRI scheduled for 6/19/24. Patient requiring evaluation and management of disease processes and visit completed.<br><br>Interview on 7/25/2024 at 3:36 p.m., with RN A, said Resident #22's diagnosis of pneumonia was not care planned and it should have been care planned. She said when she put the antibiotic on the care plan, she did it for sepsis and not for pneumonia. She said if he is on antibiotics for pneumonia, it should be documented in his care plan. She said she was not aware that it was missed on his care plan. She said next time she will do it. She said it was important to have the diagnosis on the care plan because you must be able to assess the resident. She said you cannot trace back or follow interventions if it's not care planned.<br><br>Interview on 7/25/2024 at 4:02 p.m., with the MDS Nurse, she said Resident #22's diagnosis of pneumonia was not care planned. She said it should have been care planned. She said all of it should have been care planned. She said it was important to have his diagnosis of pneumonia on the care plan to monitor for respiratory interventions because it could affect swallowing. She said she would get with DON, and IDT and they will come up with a plan to improve care plans.<br><br>Interview on 7/25/2024 at 4:13 p.m., with the ADON, she said if Resident #22's diagnosis was on the care plan, it could help track where the infection was going. She said she would form a team with IDT and find a better way to go about care plans. she said it was a diagnosis it should have been on the care plan. She said she just started her position, and she was still learning what things go on the care plans. She said she would find out from the DON.<br><br>Record review of the facility's policy titled Comprehensive Resident Centered Care Plan revised on (12/2023) read in part . The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. Cultural Competency - is a process of achieving achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Resident's Goal - refers to the resident's desired outcomes and preferences for admission, which guide decision-making during care planning. Interventions - are actions, treatments, procedures, or activities designed to meet an objective. Measurable - is the ability to be evaluated or quantified. Objective - is a statement describing the results to be achieved to meet the resident's goals. 1. Within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care. 2. The baseline-care plan will include the minimum healthcare information necessary to properly care for a resident including, but not limited to: a) Initial goals based on admission orders, b) Physician orders, c) Dietary orders, d) Therapy services, e) Social services; and f) PASARR recommendations, if applicable . |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392<br><br>Based on observations, interviews, and record review, the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 12% based on 3 errors out of 25 opportunities, which involved 3 of 14 residents (Residents #274, #77 and #14) reviewed for medication errors.<br><br>-MA L did not administer the full dose of Trintellix (vortioxetine) HBr (a medication used to treat major depressive disorder) to Resident #274 as ordered by the Physician.<br><br>-MA L administered Multi-Vitamin with Minerals to Resident #77 instead of Ocuvit eye + Multivitamin with Minerals (a medication used to help protect eye health) as ordered by the Physician.<br><br>-RN T administered Lidocaine Patch 5 % (a medication used to help relieve pain) to Resident #14 instead of Aspercream 4% Lidocaine as ordered by the Physician.<br><br>These failures could place residents at risk of not receiving the intended therapeutic benefits of prescribed medications.<br><br>Findings Included:<br><br>Record review of Resident #274's face sheet dated 07/24/2024 revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hypothyroidism (a condition where the thyroid gland does not produce enough hormones), major depressive disorder, hypertension (high blood pressure readings) and malaise (a general feeling of being ill, unhappy or uneasiness).<br><br>Record review of Resident #274's MDS (a Resident Assessment and Care Screening) dated 07/23/2024 revealed no pertinent data due to the MDS was still in progress.<br><br>Record review of Resident #274's undated care plan included Focus - at risk for impaired cognitive function/dementia or impaired thought process. Goal - will remain oriented to (person, place, situation, time) through the review date. Interventions included - communication: Use simple, directive sentences. Provide with necessary cues-stop and return if agitated. Focus - ADL self-care performance deficit. Interventions included Resident #274 required assistance from staff with all ADLs. Further review revealed major depressive disorder was not addressed.<br><br>Record review of Resident #274's Psychoactive Medication Therapy Informed Consent Form dated 07/17/2024 and signed by Resident Representative, revealed Psychoactive Medication Prescribed: Vortioxetine for Depression: feeling down, depressed, or hopeless.<br><br>Record review of Resident #274's Physician Orders as of 07/24/2024 included an order for Vortioxetine oral tablet 10mg, give 1 tablet by mouth one time a day for Depression.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #274's MAR for July 2024 revealed MA L documented administering Vortioxetine 10mg on 07/24/24 at 7:30 AM. Further review revealed MA L documented that she gave Vortioxetine 10mg on the following dates: 7/19/24, 7/20/24, 7/21/24 and 7/22/24. MA E documented as administered on 7/23/2024.<br><br>In an observation on 07/24/2024 at 8:20 AM, MA L prepared Resident #274's medication. Observation of the label on the blister packet for Trintellix tablet 5mg, indicated a dispense date of 7/18/24, read quantity of 7. The blister pack for Trintellex contained 2 tablets prior to MA L administering one 5mg tablet to Resident #274. Resident #274 was sitting up in bed, alert, watching TV. Resident #274 was cooperative and did not speak when greeted.<br><br>In an interview on 07/24/2024 at 3:00 PM, MA E confirmed her initials on Resident #274's MAR for July 2024. MA E stated she gave Vortioxetine 5mg x 2 tablets to Resident #274 on 07/23/2024. MA E stated if Resident #274 received a lower dose than what was ordered then it would not be following orders and that it may not be as effective for depression.<br><br>In an interview on 07/24/2024 at 5:25 PM, the DON said she expected whoever discovered the discrepancy with Resident #274's Vortioxetine (Trintellix) to notify the Charge Nurse right away. The Surveyor asked the DON about the effects of receiving a lower dose. The DON stated Resident #274's mood had not changed from admission and the plan was for Psychiatry to evaluate her.<br><br>In an interview on 07/25/2024 at 12:28 PM, MA L stated the step she takes prior to administering medications include checking the name on the E-MAR, make sure the name matches on the screen and name on the door, match the ordered dose and the name of the drug matches the blister pack. The Surveyor asked MA L why she gave Vortioxetine 5mg to Resident #274 when the order was for 10mg. MA L stated she just missed and overlooked it and that it was a mistake by the pharmacy who sent the wrong dose. MA L did not have an answer as to why she did not notify the supervisor prior to administration when she saw the discrepancy. MA L stated she told the DON afterwards. The Surveyor asked if she gave 10mg on dates she documented as giving Vortioxetine 10mg on 7/19/24, 7/20/24, 7/21/24,7/22/24, that the blister pack originally contained seven 5 mg tablets on 7/18/24 and that had she given the ordered dose of 10mg, the blister pack had enough full doses for only 3 days and more would have had to been ordered starting 7/22/24. MA L had no comments. MA L stated she would look more carefully next time if it were to happen again, and the blister pack did not match the physician order, then she would notify the nurse right away. MA L stated she had orientation on 6/1/2024 and had 2 weeks on the floor for training on giving medications.<br><br>In an interview on 07/25/2024 at 1:55 PM, with RN A and the DON, the DON stated the ball was dropped and the pharmacy had not been consistent with delivery of medications. The DON stated the pharmacy did not send the 10mg of Vortioxetine. The DON stated RN A had caught the error for Resident #274's Vortioxetine order during medication reviews on 07/18/2024 for newly admitted residents. RN A stated she placed an order for the correct dose in the computer which directly linked to the pharmacy. The DON stated she was putting more trust in the nurses and med aides that they would follow procedures. The DON stated, what should have happened was that a change of order sticker be placed on the package of Vortioxetine 5mg, to alert the nursing staff and to make sure the correct order/dose was administered.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #274's Order Audit Report dated 07/24/2024 revealed the order summary was for Vortioxetine oral tablet 10mg, give 1 tablet by mouth one time a day for Depression and was created by RN A on 07/18/2024. The Order Supply Summary revealed there was Trintellix (Vortioxetine) 5mg on hand and that the form was auto linked to the pharmacy.<br><br>Record review of Resident #77's face sheet dated 07/2/42024, revealed a [AGE] year-old female admitted to the facility on [DATE] and originally admitted on [DATE]. Her diagnoses included Alzheimer's disease, Diabetes, need for assistance with personal care, muscle weakness, dementia, hyperlipidemia, polyosteoarthritis, age related osteoporosis and HTN.<br><br>Record review of Resident #77's Physician's Progress Note, DOS 06/26/2024 by the APRN revealed the resident had a past medical history of macular degeneration (a vision impairment resulting from deterioration of the retina).<br><br>Record review of Resident #77's quarterly MDS dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. MDS revealed she had adequate vision and that she did not use corrective lenses. She required partial to substantial assistance from staff with ADLs.<br><br>Record review of Resident #77's undated care plan revealed Focus - at risk for impaired visual function r/t macular degeneration. Goal - will have no indications of acute eye problems through the review date. Interventions - Review medications for side effects which affect vision.<br><br>Record review of Resident #77's Physician Orders as of 07/24/2024 included an order for artificial tears 2 drops to both eyes every 12 hours PRN for eye irritation. Eyelid Cleansers pad everyday shift for discharge from eyes. Occuvite Eye and Multi Vitamins-Minerals, give 1 tablet by mouth one time a day for supplement, order date 10/12/2022.<br><br>Record review of Resident #77's MAR for July 2024 revealed Occuvite Eye + Multivitamin with Minerals, give 1 tablet by mouth one time a day for Supplement and scheduled for 7:30 AM.<br><br>Record review of Resident #77's eye exam dated 04/09/2024 and written by the Eye Doctor revealed her chief complaint was blurred vision, itching, burning, and watering eyes. Medication included Occuvite eye 1 tablet every day.<br><br>In an observation and interview on 07/24/2024 at 8:30AM, MA L checked Resident #77's BP. Results were 230/98, 76 pulse. MA L notified the RN P of the elevated BP result. MA L prepared Resident #77's medications including a Multi vitamin with minerals 1 tablet. Resident #77 was sitting in her wheelchair just inside her bedroom door. She was alert and pleasant. Resident was rubbing her eyes and said to MA L that she wanted eye drops. MA L stated she would let the nurse know.<br><br>In an interview on 07/25/2024 at 12:06 PM, MA L stated the Occuvit Eye supplement was for Resident #77's eyes. MA L stated she gave the correct medication because in the physician orders it read Multivitamins with minerals. MA L stated she did not know what the difference was until the Surveyor explained that the Physician Order read Occuvit Eye and Multivitamins with Minerals. MA L stated she was not clear what the medication was for but that it could be why her eyes were itching. MA L stated she recently received inservice on medication administration around 7/19/24 or 7/22/2024 as well as on 07/24/2024.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #14's face sheet dated 07/25/2024 revealed a [AGE] year-old female admitted on [DATE] and originally admitted on [DATE]. Her diagnoses included Alzheimer's disease, Diabetes, bipolar disorder, anxiety, osteoarthritis, difficulty walking, dementia, muscle weakness and depression.<br><br>Record review of Resident #14's Physician's Progress Note, DOS 07/18/2024, written by the APRN/FNP read in part: .Assessment and Plan .Osteoarthritis/Lower Back Pain-chronic illness with progression .<br><br>Record review of Resident #14's quarterly MDS dated [DATE] revealed a BIMS score of 14 out of 15 indicating intact cognition. She was independent with all ADLs. She required supervision with tub/shower transfers.<br><br>Record review of Resident #14's undated care plan revealed, Focus - Resident #14 has acute/chronic pain r/t generalized pain. Goal - Will not have an interruption in normal activities due to pain. Interventions included - monitor/document for side effects of pain medication. Pain assessment every shift. Further review revealed low back pain was not specifically addressed.<br><br>Record review of Resident #14's Physician Orders active as of 07/25/2024 revealed Aspercreme 4% Lidocaine Dx: pain, every 12 hours, apply to lower back, order date 04/22/2024. Further review revealed no order for Lidocaine 5 % patch.<br><br>Record review of Resident #14's MAR for July 2024 revealed Aspercreme 4% Lidocaine was scheduled for 9:30 AM and 9:30 PM. RN T documented administration on 07/25/2024 at 9:30 AM.<br><br>In an observation on 07/25/2024 at 3:30 PM, RN T applied Lidocaine 5% patch to Resident #14's lower back as Resident #14 stood up holding on to her walker.<br><br>In an interview on 07/26/2024 at 11:12 AM, the DON said the Lidocaine 5% patch was not the same as Aspercreme 4% Lidocaine. The DON checked records for Resident #14 and said there was no one time order found for Lidocaine 5% patch. The DON said Resident #14 did have an order for Lidocaine 5% patch that was discontinued in April 2024. The DON stated RN T should have clarified the order prior to administration. The DON stated Resident #14 was receiving the Aspercreme 4% Lidocaine patch for the diagnosis of pain. The DON stated Resident #14 probably had a shower and needed the pain patch replaced afterwards and that would explain why a patch was administered in the afternoon. The Surveyor asked the DON what the risks were to the resident. The DON stated Resident #14 could develop an adverse reaction to the Lidocaine 5 % patch or it could not be effective at all in reducing the pain. The DON stated moving forward she will provide 1 one 1 education with RN T.<br><br>In a telephone interview on 07/26/2023 at 1:30 PM, RN T stated she gave Resident #14 the ordered pain patch in the afternoon of 07/25/2024. RN T stated it was not true that she did not give something that was not ordered. RN T stated she did not remember what all happened the previous day and would need to come in to work and look at the computer to see what happened. RN T called Surveyor at 1:43 PM and said she was unable to come in to work to check Resident #14's records due to an emergency.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 07/26/2024 at 1:38 PM, Resident #14 said the patch to her lower back helps with her pain and they always apply a patch vs a cream. Resident #14 stated she got a shower around 2:30 PM on 07/25/2024 and recalls she did have a pain patch in the morning. She stated it would have had to come off and then a new one put back on after her shower.<br><br>Record review of MA L's Skills Checklist for Oral Medication Pass dated 6/17/24 revealed MA L demonstrated competency including verifying medication and strength with order as prescribed.<br><br>Record review of RN T's Orientation and Annual Skills Checklist dated 6/07/2024 revealed she met the requirements including Understanding Medication Pass Procedure Including Charting: Rights of Medication Administration, PRN pain medications.<br><br>Record review of the facility Staff Development/Inservice Attendance Sheet dated 06/10/2024 for Medication Administration, presented by the DON/RN A included the 12 Rights of Medication Administration: Right Resident, Right Dose, Right Route, Right Time, Right Response, Right Reason, Right Documentation, Right Assessment and Evaluation, Right Resident Education, Right to Refuse Medication and Right Expiration Date. MA L signed the sheet.<br><br>Record review of the facility's Medication Administration policy, revised on 05/2007, read in part: .It is the policy of this facility that medications shall be administered as prescribed by the attending physician 14. Prior to administering the resident's medication, the nurse or MA should compare the drug and dosage schedule on the Resident's E-MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse should check the physician's orders . |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392<br><br>Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 2 of 2 residents (Residents #71 and #1) reviewed for medical records accuracy, in that:<br><br>Resident #71's June 2024 MAR documentation was incomplete. RN M failed to document or sign off on the administration of physician ordered Oxycodone with Acetaminophen (a controlled substance) for pain.<br><br>Resident #1's April 2024 MAR documentation was incomplete. RN M failed to document or sign off on the administration of physician ordered Hydrocodone with Acetaminophen (a controlled substance) for pain.<br><br>Facility staff failed to sign the correct narcotic count sheet for Resident #71's Oxycodone with Acetaminophen. RX301757108.<br><br>Facility staff failed to sign the correct narcotic count sheet for Resident #1's Acetaminophen/Codeine (a controlled substance) .RX301621561.<br><br>This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment.<br><br>Findings included:<br><br>1. Record review of Resident #71's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] and originally admitted on [DATE]. Her diagnoses included metabolic encephalopathy (a change in how the brain works and can cause confusion), Diabetes (a chronic condition characterized by elevated levels of blood glucose), Crohn's disease (a condition that affects the digestive tract), knee pain, leg pain, Parkinsonism (an umbrella term for conditions that affect movement), dementia, lumbosacral plexus disorders (a disorder of the peripheral nervous system affecting the lower back), chronic pain syndrome, depression, and bipolar disorder.<br><br>Record review of Resident #71's quarterly MDS dated [DATE] revealed a BIMS score of 15 out of 15, which indicated intact cognition. She required substantial assist with personal hygiene and toileting hygiene, partial assistance with lower body dressing. She required supervision with transfers. She used a manual wheelchair for mobility. She had occasional pain over the last 5 days and the pain rarely interfered with sleep. She was receiving speech therapy, occupational therapy and physical therapy starting 01/12/2024.<br><br>Record review of Resident #71's undated care plan revealed Focus - has acute/chronic pain r/t lower back pain, old wedge compression fracture of lumbar area and neuropathy (nerve damage). Interventions included: Administer analgesic medication as per orders. Anticipate need for pain relief and respond immediately to any complaint of pain.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #71's Physician Orders active as of 07/25/2024 revealed an order for Percocet oral tablet 10-325mg (Oxycodone with Acetaminophen) give 1 tablet by mouth every 24 hours as needed for pain, order date 12/16/2023.<br><br>Record review of the associated Narcotic Count Sheet for Resident #71's Oxycodone with Acetaminophen 10-325mg revealed on 06/06/2024 at 9:00 PM, RN M signed out one tablet.<br><br>Record review of Resident #71's MAR for June 2024 revealed no documentation Oxycodone with Acetaminophen 10-325mg was administered on 06/06/2024.<br><br>Record review of Resident #71's Progress Notes dated 05/25/2024 to 06/25/2024 revealed no documentation that Oxycodone with Acetaminophen 10-325mg was administered on 06/06/2024.<br><br>Record review of the associated Narcotic Count Sheet for Resident #71's Oxycodone with Acetaminophen 10-325mg revealed on 06/09/2024 at 3:00 AM, RN M signed out one tablet.<br><br>Record review of Resident #71's MAR for June 2024 revealed no documentation that Oxycodone with Acetaminophen 10-325mg was administered on 06/09/2024.<br><br>Record review of Resident #71's Progress Notes dated 05/25/2024 to 06/25/2024 revealed no documentation that Oxycodone with Acetaminophen 10-325mg was administered on 06/09/2024.<br><br>Record review of the associated Narcotic Count Sheet for Resident #71's Oxycodone with Acetaminophen 10-325mg revealed on 06/19/2024 at 9:00 PM, RN M signed out one tablet.<br><br>Record review of Resident #71's MAR for June 2024 revealed no documentation that Oxycodone with Acetaminophen 10-325mg was administered on 06/19/2024.<br><br>Record review of Resident #71's Progress Notes dated 05/25/2024 to 06/25/2024 revealed that no documentation Oxycodone with Acetaminophen 10-325mg was administered on 06/19/2024.<br><br>Record review of the associated Narcotic Count Sheet for Resident #71's Oxycodone with Acetaminophen 10-325mg revealed on 06/20/2024 at 9:00 PM, RN M signed out one tablet.<br><br>Record review of Resident #71's MAR for June 2024 revealed no documentation that Oxycodone with Acetaminophen 10-325mg was administered on 06/20/2024.<br><br>Record review of Resident #71's Progress Notes dated 05/25/2024 to 06/25/2024 revealed that no documentation Oxycodone with Acetaminophen 10-325mg was administered on 06/20/2024.<br><br>Record review of the associated Narcotic Count Sheet for Resident #71's Oxycodone with Acetaminophen 10-325mg revealed on 06/28/2024 at 9:00 PM, RN M signed out one tablet.<br><br>Record review of Resident #71's MAR for June 2024 revealed that no documentation Oxycodone with Acetaminophen 10-325mg was administered on 06/28/2024.<br><br>Record review of Resident #71's Progress Notes dated 06/25/2024 to 07/26/2024 revealed that no documentation Oxycodone with Acetaminophen 10-325mg was administered on 06/28/2024.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676230 | A. Building<br>B. Wing | 07/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Copperfield Healthcare and Rehabilitation | 7107 Queenston Blvd<br>Houston, TX 77095 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Record review of Resident #1's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included fracture to the left hip, urinary tract infection, muscle weakness, difficulty walking, dementia, Alzheimer's disease, deaf non-speaking, heart disease and chronic kidney disease.<br><br>Record review of Resident #1's quarterly MDS dated [DATE], revealed she had short term and long-term memory problems. She had severely impaired cognitive skills for daily decision making. Her hearing was highly impaired, and she had no speech. She was dependent on staff for all ADL needs. She received scheduled pain medication in the last 5 days.<br><br>Record review of Resident #1's undated care plan revealed she had a history of left hip fracture. Interventions included monitor/document/report to MD PRN s/sx of hip fracture complications such as unrelieved pain. Resident #1 had an arterial ulcer to the right foot. Interventions included analgesics as ordered.<br><br>Record review of Resident #1's active Physician Orders as of 07/26/2024 revealed an order for Acetaminophen-codeine tablet 300-30mg, give 1 tablet by mouth every 8 hours as needed for pain, order date 04/11/2024.<br><br>Record review of the associated Narcotic Count Sheet for Resident #1's Acetaminophen-codeine tablet 300-30mg revealed on 03/23/2024 at 9:00 PM, RN M signed out one tablet.<br><br>Record review of Resident #1's MAR for March 2024 revealed no documentation that Acetaminophen-codeine tablet 300-30mg was administered on 03/23/2024.<br><br>Record review of Resident #1's Progress Notes dated 02/23/2024 to 03/25/2024 revealed no documentation Oxycodone with Acetaminophen 10-325mg was administered on 03/23/2024.<br><br>During a review on 07/24/2024 at 11:50 AM, of the 300 Hall Nurse Medication Cart revealed:<br><br>-Resident #1's blister packs for APAP/Codeine tablet 300-30mg with RX301621561, dated 4/11/2024 had 81 tablets. The Count sheet read 81 tablets. The pharmacy label on the Count Sheet read: Resident #1 Hydrocodone/APAP tablet 5-325mg, RX301616097, dated 04/09/2024, and signed as received by RN M on 4/9/24.<br><br>-Resident #71's blister pack for Oxycodone/APAP tablet 10-325mg, RX301757108, dated 05/29/2024 had 7 tablets. The Count sheet read 7 tablets. The pharmacy label on the accompanying Count Sheet read Resident #71, Oxycodone/APAP tablet 10-325mg, RX301598707, dated 4/03/24 and signed as received by RN M on 4/3/24.<br><br>In an interview on 07/24/2024 at 12:00 PM, LVN C stated she did not know why the pharmacy labels on the blister packs for Resident #1's APAP/Codeine and Resident #71's Oxycodone/APAP did not match with the pharmacy labels on their respective count sheets. LVN C stated that when she signed out Narcotics, she made sure the resident name, the drug and dose match the physician orders and she did not look at the expiration dates and did not look to see if the RX numbers match up. LVN C stated regarding the pharmacy labels on the count sheets she did not know where the blister pack for Resident #1's Hydrocodone/APAP RX301616097 and blister pack for Resident #71's Oxycodone/APAP RX301598707 were located.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 07/24/2024 at 1:20 PM, the DON and RN A stated the Nurses were signing Resident #1's APAP/Codeine on the count sheet for Hydrocodone/APAP, which was incorrect. The DON stated Resident #1's Hydrocodone/APAP was discontinued and that she still had the blister pack and count sheet because she was still deciding on what to do with it. The count sheet for Resident #1's APAP/Codeine tablet 300-30mg with RX301621561 was switched with the count sheet for the Hydrocodone/APAP RX301616097. The DON stated Resident #71's Oxycodone/APAP, RX301757108 was signed out on a Count Sheet for the same drug but different pharmacy label: RX number (RX301598707). The DON stated Resident #71's Oxycodone/APAP RX301598707 was completed and no longer had the blister pack because it was empty and thrown out. The DON stated the nurses should be matching all information when signing out narcotics, including the RX number and not just counting pills. The DON stated also the nurse accepting the narcotics was responsible for accurate documentation. RN A stated they will be calling in all the nurses who signed out the narcotics and will conduct in-services. The DON and RN A stated they will also audit all the medication carts.<br><br>Record review of Resident #1's Audit Report dated 07/25/24 revealed Hydrocodone/APAP 5-325mg was discontinued on 04/11/24.<br><br>Record review of Resident #1's discontinued blister pack for Hydrocodone/APAP RX301616097, contained 3 tablets. The accompanying undated white invoice sheet noted RX301616097 was discontinued, with 2 nurse signatures. The accompanying pink count sheet noted there were 3 tablets, and the pharmacy label was for Resident #1's APAP/Codeine 300-30mg, RX301621561.<br><br>In an interview on 07/25/2024 at 1:52 PM, the DON stated that the importance of the count sheet was to keep track of the narcotics to ensure the rights of medication administration was implemented, to follow all the 7 rights so they can keep track and hold the nurses accountable when giving the medications. The DON stated the responsibility for maintaining records for controlled substances goes through the chain of command. The DON stated the charge nurses were responsible if any discrepancies were found, they would then call the pharmacy, the DON, RN A and notify the MD and resident/RP. The DON stated it is part of accountability, responsibility and is simply basic Nursing 101. The DON stated she and RN A oversee the narcotics. The State Surveyor asked the DON what the risks would be if records were inaccurate. The DON stated the risks were drug diversion, the resident could have an adverse reaction and misuse of narcotics. The DON stated the Nurse Managers (RN A, ADON, DON, MDS nurse, Resource Nurse, Social Worker) ensures the records are reconciled and the medications are transcribed correctly. The DON stated, moving forward she and RN A and the other ADONs will be checking resident charts and count sheets as well as conducting staff inservices, including reminding staff when signing out narcotics to document right after administering the medications and not waiting until a later time.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 07/26/2024 at 10:00 AM, the DON stated RN M was no longer employed at the facility as of last week. She did not know the exact date. The DON stated RN M usually worked on 300 Hall. The DON stated she wanted RN M to work alongside of one of the LVNs in 200 Hall and RN M refused when told to do so. The DON stated RN M then quit and did not return. The DON stated, regarding Resident #71's Oxycodone/APAP signed out by RN M and no documentation they were administered, she stated she cannot say they were given and cannot say they were not. The State Surveyor asked the DON about how she would ensure other resident's medications were not inaccurately documented. The DON stated her plan was to implement monitoring, doing the check on narcotics when they are delivered from pharmacy on Mondays, Wednesdays, and Fridays. The DON stated she will start more in-depth inservices for the nurses. The DON stated it was very important that the check mark boxes were accurate, so the facility knows when the medications were administered.<br><br>In an interview and observation on 07/26/2024 at 12:29 PM, Resident #1 was sitting up in bed, alert and eating lunch. She did not respond verbally to a greeting. She was in no apparent distress. Resident #1 resided in 300 Hall.<br><br>In a telephone interview on 07/26/2024 at 1:20 PM, State Surveyor asked RN M if she signed out and administered Oxycodone for Resident #71 on the following dates: 6/6/24 at 9:00 PM, 6/09/24 at 3:00 AM, 6/19/24 at 9:00 PM, 6/20/24 at 9:00 PM, 6/28/24 at 9:00 PM and Hydrocodone for Resident #1 on 3/3/24 at 9:00 PM. RN M stated she could not recall the specific dates but that some days got busy, and she may have forgotten to document. RN M stated Resident #71 would get her pain medication on time and if not, the resident would remind her, so this is how she knew she gave her pain medication. RN M stated she was very sorry and should have documented and that she cannot lie as she is an RN. RN M stated she recalls giving Resident #1 her pain medication because the resident had a sacral wound and would cry from the pain. RN M stated there were so many distractions when working but she knows she gave those medications.<br><br>Interview on 07/26/2024 at 1:38 PM, Resident #71, who resides in 300 Hall, stated she takes Oxycodone for pain in her knees and legs. She stated it does help with the pain but knows she can only have it once a day. She stated she does not use it daily and cannot remember how often she had taken it in the past. She stated when she needs the Oxycodone she asks, and the nurse always gives it to her.<br><br>In a telephone interview on 07/26/2024 at 2:25 PM, the Consultant Pharmacist stated the DON notified him that there had been inaccuracies with narcotic count sheets. He stated when he does audits quarterly, he randomly chooses PRN and routine medications. He stated everyone is responsible for the accuracy of count sheets and the facility should always have a trail of records and make sure medication labels match up. He stated ensuring the count and all information was accurate is important for proper documentation. Consultant Pharmacist stated if he found any discrepancies, he would dig deeper to find out what happened to any medication not accounted for.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 07/26/2024 at 5:15 PM, the Administrator stated overall the DON and RN A were responsible for maintaining accuracy of documentation and narcotics. The Administrator stated her expectations of the staff were to ensure they follow correct protocols/follow policies and procedures when administering medications. The Administrator stated the nursing staff should sign medications out properly and timely for correct documentation and accurate medical record purposes. The State Surveyor asked the Administrator how she would ensure other resident's medication records were not disorganized or inaccurate. The Administrator stated she would follow up with evaluating, conduct a root cause analysis to determine what happened, and why the system was broken and needed fixing. The Administrator stated it was importance to make sure the residents get the correct medications as it is a liability for the facility if not done so.<br><br>Record review of RN M's Orientation and Annual Skills Checklist dated 3/31/2024 revealed she met the requirements including Understanding Medication Pass Procedure Including Charting: Rights of Medication Administration, PRN pain medications.<br><br>Record review of the facility's policy and procedure for Medication Administration, Administration of Drugs, revised on 05/2007, read in part: .It is the policy of this facility that medications shall be administered as prescribed by the attending physician. Procedures: .3. All current drugs and dosage schedules must be recorded on the resident's medication administration record (EMAR) .9. The nurse or MA administering the medications must document in the E-MAR, upon completion of the resident's medication administration. 10. When PRN medications are administered, the nurse must record: A. The date and time administered; B. The dosage; C. the route of administration .E. Any complaints or symptoms for which the drug was administered; F. Any results achieved from administering the drug and the time such results were observed, and G. The signature and title of the person administering the drug .<br><br>Record review of the facility's policy and procedure for Medication Administration, Controlled Drugs, revised on 05/2007, read in part: .It is the policy of this facility to: 1. Provide physical facilities and method of operation for the administration and control of narcotics, depressants, and stimulants which will meet the requirements of State and Federal narcotic enforcement agencies. 2. Insure maximum safety for residents and nursing personnel .<br><br>Record review of the facility's policy and procedure for Drug Diversion Reporting and Response, revision/review date of 12/2023, read in part: .Definitions: Reconciliation refers to a system of recordkeeping that ensures an accurate inventory of medications by accounting for controlled medications that have been received, dispensed, administered, and/or, including the process of disposition . |