STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676241	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhill Villas	2530 Greenhill Rd Mount Pleasant, TX 75455

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** 47612 Based on interviews and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 6 residents (Resident #1) reviewed for pharmacy services. The facility failed to follow orders from [DATE] to [DATE] and administered to Resident #1, Aricept (Alzheimer medication), and Meloxicam (nonsteroidal anti-inflammatory medication) after the medications were discontinued. This failure could place residents at an increased risk for inaccurate drug administration and not receiving the care and services to meet their individual needs. Findings included: Record review of the face sheet, dated [DATE], revealed Resident #1 was a [AGE] year-old female admitted on [DATE] for five day respite care and discharge date [DATE], with diagnoses of Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills), and unspecified osteoarthritis, unspecified site (the most common type of arthritis and can affect any joint in the body, but it's most common in the knees, hips, spine, and hands. Symptoms include pain, swelling, and reduced motion in the joints). Record review of the discharge MDS, dated [DATE], revealed Resident # 1 had a BIMS score of 02 indicating severe cognitive impairment. Resident #1 required assistance for dressing, bathing, transferring, standing and walking. The MDS revealed Resident #1 did not reject care. Record review of an order summary, dated [DATE], revealed Resident # 1 had an order for Meloxicam 15mg give 1 tablet by mouth once daily with food. No stop date indicated. Record review on [DATE] of Resident #1skilled nursing visited dated [DATE], Resident #1 was found in her room lying on the floor. Record review on [DATE] of Resident #1 MARs for August, September, and [DATE] indicated she received Meloxicam 15mg with meals three times a day ,d+[DATE]-,d+[DATE] (not receiving Meloxicam at 5:00 pm on ,d+[DATE] and ,d+[DATE]), ,d+[DATE]-[DATE], and ,d+[DATE]-[DATE]. (continued on next page)

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 Resident #1's medication administration record dated [DATE] - [DATE], indicated Resident # 1 received Aricept 10 mg on [DATE] at 8:00 p.m., Aricept 10 mg on [DATE] at 8:00 p.m., Aricept 10 mg on [DATE] at 8:00 p.m., Aricept 10 mg on [DATE] at 8:00 p.m. Record review of Resident #1's MAR record dated [DATE] - [DATE], indicated Resident # 1 received Meloxicam 15mg on [DATE] at 7:00 a.m., at 12:00 p.m., and 5:00 p.m., and Meloxicam 15mg on [DATE] at 7:00 a.m., at 12:00 p.m., and 5:00 p.m., Meloxicam 15mg on [DATE] at 7:00 a.m., at 12:00 p.m., and 5:00 p. m., Meloxicam 15mg on [DATE] at 7:00 a.m., at 12:00 p.m., and 5:00 p.m. During an interview on [DATE] at 10:20 a.m., Resident #1's family member stated Resident # 1 was at the facility from [DATE] to [DATE] for respite care. Resident #1's family member stated during the stay Resident #1 had a fall which left a bruise on her check and a black eye. Resident #1's family member stated Resident #1 was readmitted to the facility [DATE] to [DATE] for respite care, at which time Resident #1's family member left her current medications at the facility. Resident #1's family member was informed Resident #1 was given the wrong medication of Aricept, and Meloxicam was given three times a day instead of once a day. Resident #1's family member stated Resident#1's current medications she should have received were Ativan (anti-anxiety), Gabapentin (peripheral neuropathy/ pain), Cymbalta (depression/anxiety), Hydrochlorothiazide (diuretic), Meloxicam (nonsteroidal anti-inflammatory medication), and Hydromorphone (narcotic). Resident #1's family member stated when she picked Resident#1 up she would not open her eyes or transfer into the truck. Resident #1's family member stated when she got Resident #1 home the tops of her feet were skinned up because the staff were not putting shoes and socks on Resident #1's feet. During an interview on [DATE] at 2:45 p.m., MA A stated she did not remember giving Aricept to Resident # 1. MA A stated she would give residents their ordered medications. MA A stated if she gave the wrong medication, she would report it to the charge nurse and the Administrator. MA stated the charge nurse was responsible for putting medication orders into the system. MA A stated she was recently in-serviced on medication administration. MA A stated she remembered Resident # 1 because she would gum her medication and she had to check to make sure she swallowed the medications. MA A stated she did not witness Resident #1 fall, but she did witness Resident #1 stand up from her chair and just sit down on the floor. MA A was able to name the 5 rights of medication administration. During an interview on [DATE] at 3:00 p.m., LVN B stated she had been working back at the facility for 2 weeks. LVN B stated she was not familiar with Resident #1. LVN B stated she had been in-serviced over medication administration. LVN B stated hospice hand delivered orders and faxed orders when the resident admits or there was a change of condition. LVN B stated it was the charge nurse's responsibility for putting orders into the system. LVN B stated if she was to administer the wrong medication she would assess the resident, notify the DON, the doctor, and the family. LVN B was able to name the 5 rights of medication administration. During an interview on [DATE] at 3:18 p.m., RN C stated she was Resident #1's hospice nurse. RN C stated the family brought concerns to them after Resident # 1 was home. RN C stated when a resident admitted to the facility or if there was a change in condition the hospice nurse would hand deliver orders at the time of admission or shortly after, then the orders were faxed to the facility as well. RN C stated Resident #1 was confused and unable to transfer due to Alzheimer's disease process. (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 [DATE] at 3:25 p.m., LVN D stated she made a mistake and put Resident # 1's orders on [DATE] in the system incorrectly. LVN D stated she was in a hurry and just entered Resident #1's orders into the computer incorrectly. LVN D stated she did not immediately get the orders from hospice. LVN D stated it was important to give the correct medication, so the resident did not have an adverse reaction. LVN D stated she did not witness Resident #1 fall; however, LVN D stated Resident #1 would stand up out of her chair and sit on the floor. LVN D stated she was no longer working at the facility since the incident. During an interview on [DATE] at 3:45 p.m. the DON stated Resident # 1 came to the facility for respite care. The DON stated it was important for the orders to be correct in the system so the resident would receive the care they required. The DON stated the nurse who does the admission was responsible for putting the orders into the system. The DON stated the nurse putting the orders in should go back over the orders to make sure they were in the system correctly. The DON stated she did a medication audit of the whole building and checked all medications against the orders. The DON stated LVN D was terminated after the incident. The DON stated she will monitor by in-service and will watch medication pass for five different residents five times a week. The DON stated the hospice nurse had to stay in the facility until the charge nurse puts the orders in the system then they will both verify the orders. During an attempted phone interview on [DATE] at 8:42 a.m. LVN E did not answer, left voicemail. During an interview on [DATE] at 8:56 a.m. the Regional Compliance Nurse stated Resident #1 did receive the Aricept and Meloxicam. The Regional Compliance Nurse stated LVN D was terminated, and a medication audit was completed to ensure all medication orders were in the system correctly. During an attempted phone interview on [DATE] at 9:06 a.m. LVN E did not answer, left voicemail. During an interview on [DATE] at 9:15 a.m. the Medical Director stated he was informed Resident #1 received Aricept and Meloxicam in error. The Medical Director stated he expected the nurses to put the orders into the system correctly. The Medical Director stated two nurses should verify the orders as well as the hospice nurse and pharmacy. The Medical Director stated he did not discontinue the Aricept. The Medical Director stated the medication aide, nurse, or pharmacy should have caught Meloxicam being given three times a day with meals instead of one time a day with a meal as ordered. The Medical Director stated he did not feel Resident #1 suffered any negative effect from the medication error. The Medical Director stated he did not give new orders since the Meloxicam was an anti-inflammatory and low risk for concern. During an interview on [DATE] at 10:54 a.m., the Pharmacy Tech said the facility had not pulled any medications from the emergency kit between [DATE] and [DATE] for Resident# 1. During an interview on [DATE] at 10:57 a.m., the Pharmacist said in her professional opinion a person who was given Meloxicam 15mg three times a day for a 5-day duration if side effects were present would mainly experience GI upset and possible GI bleed or ulcer. The Pharmacist said Meloxicam could cause dizziness, lethargy, and decrease in potassium levels. The Pharmacist said she would recommend checking a patient's potassium level if they had been administered more than the prescribed dose of Meloxicam. The Pharmacist said Meloxicam cleared from the body quickly. The Pharmacist said Meloxicam had a half-life of 13.4 hours. (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 [DATE] at 11:15 a.m., RN C, ADON for Hospice said Resident #1 had skilled nursing visits while in the facility on ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. RN C said Resident #1 had not expired and has still receiving hospice services. RN C said the family had brought concerns to them regarding the resident after she returned home. RN C said they requested documentation from the facility and discovered the medication error. RN C said hospice made the facility aware of the medication error. RN C said they encouraged the family to increase Resident #1 fluid intake and after a few days she perked up. RN C said the family had told them they were planning to have a CT of the head performed, but hospice did not have a report for a CT. During an interview on [DATE] at 1:11 p.m. RN C said lab work obtained from [DATE] was within normal limits except for a slightly elevated AST and ALT. Record review of the Nursing Facility Medication Administration policy, undated, revealed Medications shall be administered only to the resident for whom they are prescribed, given in accordance with directions on the prescription or the Physician's orders, and recorded on the resident's medication record The facility course of action prior to surveyor entrance included: Record review of the provider investigation report dated [DATE], indicated Administrator was made aware of possible medication error and a investigation was started immediately. Notified physician and family., interviewed staff, in-serviced staff. All residents were at risk for medication error, however, two weeks of admits were reviewed, and none were found. A medication cart audit was done assuring medications were available. Medication in-service for all medication aides and nurses, 5 rights and to ensure that when administering medication verifies the medication label to the MAR. Medication aide to report to charge nurse if a medication was not available, and charge nurse to report to DON/ADON, pharmacy, and MD or NP if a medication was not available, never document a medication was given that was not administered. Charge nurses in-serviced on Medication Reconciliation upon admission with the practitioner. Regional charge nurse gave one on one in-service to DON and ADON on checking new admission/ readmission orders for accuracy. The following monitoring was in place. DON or designee will monitor a portion of a medication pass at least five times per week to ensure compliance with medication administration and all ordered medication were administered. DON or designee to interview at least six nurses and medication aides each week and ask them what they would do if medication was not available. DON or designee to interview at least six nurses and medication aides each week and ask them what they would do regarding medication for any resident returning to the facility. DON or designee at least five times per week will review all new admissions and readmissions from the previous day to ensure all those orders are transcribed into PCC correctly and that all ordered medications were available. Record review on [DATE] indicated an Ad-Hoc QAPI was held on [DATE] regarding medication error. (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 on [DATE] of an undated in-service indicated staff were in-serviced regarding pharmacy reconciliation to include upon admission staff must contact the physician for medication reconciliation and if the resident was receiving hospice service the nurse must enter all orders in PCC and verify orders are correct with hospice. Record review on [DATE] of an in-service dated [DATE] indicated staff were in-serviced regarding the 5-rights of medication administration and medication order policy including right drug, right dose, right route, right time, right patient, orders should be transcribed exactly as written, any questions regarding an orders should be clarified with the practitioner prior to initiating the order, if a medication error occurs or was discovered immediately report the finding to the physician and DON, do not mark a medication as administered if the medication was not available, medications not administered as ordered was an error. Record review of the Medication Error report dated [DATE] indicated the medication error was discovered when an audit was performed on medications with hospice. The Medication Error report indicated LVN D stated she did not properly check the orders. The Medication Error report indicated the physician was notified on [DATE]. The Medication Error report indicated the resident had already discharged from the facility. The Medication Error report indicated this was reported to state agency and the DON, Administrator, and hospice company had a meeting regarding preventing medication discrepancies and future goals for patient safety. Record review on [DATE] of pharmacy receipts/manifests from [DATE]-[DATE] indicated there were no medications delivered from the facility's pharmacy for Resident #1. Record review of LVN D's employee file indicated her last day worked was [DATE] and she was terminated on [DATE]. The Employee Disciplinary Report dated [DATE] indicated LVN D was suspended on [DATE] pending an investigation into medication errors. The Employee Disciplinary Report indicated on [DATE] it was found that LVN D violated medication administration policies and procedures. The Employee Disciplinary Report indicated the investigation concluded LVN D made medication errors resulting in patients being harmed. The Employee Disciplinary Report indicated LVN D had been made aware of the seriousness of medication distribution and had continued to make severe errors when administering medication. The Employee Disciplinary Report indicated LVN D met the criteria for immediate termination. The Employee Disciplinary Report indicated LVN D would be terminated effective immediately. The Employee Disciplinary Report was signed by LVN D, Administrator, and DON on [DATE].