STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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 - Few	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** 28637 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #1) of 6 residents reviewed for pharmacy services in that: The facility failed to ensure employees with keys used to access to controlled medication did not share those keys without first properly counting the inventory of the controlled medications. LVN A shared the keys to her medication cart, which contained a separately locked compartment for controlled medications, with LVN B during the course of their shift. LVN A later discovered 30 tablets of Oxycodone (a controlled narcotic drug), belonging to Resident #1, was missing from her medication cart at the end of her shift. The medications were never located. This failure placed residents at risk for unrelieved pain due to their medication not being readily available. Findings included : Record review of Resident #1's Face Sheet dated 2/16/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including bacterial infection; encounter for surgical aftercare following surgery on the digestive system; orthopedic aftercare following surgical amputation; acquired absence of left leg above the knee; perforation of the intestine (a hole in the intestine); peripheral vascular disease (reduced blood flow to the limbs); and chronic non-pressure ulcers of the right foot. Record review of Resident #1's MDS assessment dated [DATE] revealed she had a BIMS score of 5, indicating severe cognitive impairment. She was receiving scheduled pain medication daily, and was receiving Hospice Services. Record review of Resident #1's Patient Medication Profile dated 03/11/24 revealed her orders included the following: Order dated 07/08/2022: Oxycodone 10 mg tablet 1 tablet oral every four hours as needed for pain. Order dated 12/10/2022: Tramadol 50 mg 1 tablet oral twice a day for pain. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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 - Few	Order dated 08/17/2023: Gabapentin (used for nerve pain) 300 mg 1 tablet every 8 hours. Record review of Resident #1's medication administration records dated February 1, 2024 through March 11, 2024 reflected she had received her scheduled doses of Tramadol and Gabapentin as ordered. She had not received any doses of Oxycodone. Record review of Resident #1's nursing progress notes dated 02/01/24 through 03/11/24 revealed there were no entries reflecting Resident #1 was experiencing increasing pain requiring additional pain medication. Record review of a facility Provider Investigation Report dated 2/16/24 reflected the following: Description of the Allegation: On 2/15/24 during the narcotic count the facility was unable to locate a bubble pack containing 30 pills of 10 mg Oxycodone, that [Resident #1] receives on a PRN basis . Provider Response: Notified Physician. Notified Family and Hospice. Notified [City] Police Department [report number]. Notified Pharmacy Consultant. Drug tested [LVN A and LVN B]. Both negative. In-service Nurses and Med Aides on management of controlled medications. Suspended [LVN A]. Audited all narcotic boxes and E-kits to ensure no other narcotics were missing. A written statement by LVN A included in the report reflected: 2/15/24 Before Lunch time [LVN B] 300 H [hall] nurse came to me and asked me 'can I have your key' I asked her what do you want to do with it. She said 'I need to get some medications'. I gave her my key. She is the only person who touch my cart. During shift change we were counting the meds and we couldn't find oxycodone, this card was missing from the narcotic box. I immediately start searching with the help of other nurses but we did not find the missing medications so I notified my unit manager immediately. We all look for the missing medication but it couldn't be find [sic]. DON and Administrator aware. Signed by LVN A. A written statement by LVB B included in the report reflected: 2/15/24 I [LVB B] asked [LVN A] for her keys so I could obtain some magic mouthwash [a solution used to treat mouth sores and does not contain controlled substances]. [LVN A] gave me her keys, I walked to the cart that was on 700 (plain site [sic] of [LVN A]) and tool 30 ml of magic mouthwash, closed the cart, locked the cart and took keys back to [LVN A] who was sitting at nurses station. Signed by LVN B. Investigation Summary: On 2/15/24 [LVN A and LVN C] were counting the 700 Hall narcotics during shift change, during the counting of narcotics it was noticed that bubble pack of 30-10 mg Oxycodone were missing. [LVN A and LVN D] state that the medication was there during their previous shift change narcotic count. In an interview with [LVN A], she stated she only let [LVN B] into her cart during her shift and she was in need of a OTC medication. [LVN B] denies taking the medication. In an interview with [LVN B] she stated that she did retrieve an OTC from the medication cart. [LVN B] stated that the cart was on 700 in clear view of [LVN A] and that is the only thing she retrieved. [LVN B] denies taking any narcotics. The other staff interviews were unremarkable and offered no guidance into the missing medication. In conclusion, the facility finds the allegation unconfirmed. The facility is unable to determined [sic] the cause of the missing narcotics. All staff members deny taking the missing medications nor was there a witness. The audits yielded no other missing medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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 - Few	During an observation and interview on 03/11/24 at 9:35 AM, Resident #1 was observed in bed, under a blanket. Her right foot was exposed and propped up in a pillow. Her right great toe was completely black, the tip or right second toe was black, and a dressing was observed between the two. The top of her right foot near her toes was pink. The outline of her left leg could be seen under her blanket and was amputated above her knee. She stated she lost her left leg and had issues with her right foot due to poor circulation. She stated she does have pain in her right foot and received medications for it. She stated her medications were always available and she did not recall missing any doses or having to wait for her medicines. During an interview on 03/11/24 at 10:50 AM, the DON stated she had been heavily involved with the investigation related to Resident #1's missing Oxycodone. She stated the medications were found to be missing while LVN A was counting medications at the end of her shift with an oncoming nurse. She stated they stopped and contacted her immediately, a search was conducted and they were unable to locate the missing medication. The DON stated her investigation revealed LVN A and LVN B had breached facility policy by sharing keys without counting medications. She stated nurses counted the narcotics in the carts prior to handing off keys during every shift change and should never share keys during their shift. LVN B asked to borrow LVN A's keys to retrieve an OTC medication and LVN A admitted to handing her the keys. The DON stated the risk for sharing keys was possible drug diversion leaving residents without their medications. The DON stated nurses and medication aides had previously received in-service training prior to the incident and they all received in-service training again after the incident. The DON stated the Pharmacy Consultant was notified and a full medication audit was completed with no other medications found to be missing. She stated Resident #1 did not miss any doses of her Oxycodone and rarely requested it as she was taking scheduled pain medications. She stated the medication was immediately re-ordered as a STAT order and was replaced within approximately 2 hours at the facility's expense. The DON stated both LVNs denied taking the medication, drug screens were conducted on both nurses which came back negative. The DON stated she and her Unit Managers were monitoring medication count sheets daily. During an interview on 3/11/24 at 11:42 AM, LVN B stated she was one of the nurses investigated about Resident #1's missing pain medication. She stated she asked LVN A for her keys so she could retrieve an over-the-counter medication she had run out of. She stated she could not recall the name of the medication but remembered pulling the medication she needed and giving the keys right back to LVN A. She stated she had been written-up and drug tested as a result and received additional training. She stated the risk for sharing keys with each other was possible drug diversion and resident's not having the medications they needed to control their pain. She stated she promised she did not take any medications from anyone and had not entered the controlled medication box within LVN A's cart. LVN B stated she should not have asked to borrow another nurse's keys and stated she guessed the incident occurred because the nurses developed a trust with each other. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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 - Few	During an interview with Unit Manager E on 03/11/24 at 12:14 PM revealed she has assisted with the investigation of the incident involving Resident #1's missing medications. She stated controlled medications in medication carts were supposed to be counted during every shift change between the off-going and oncoming nurse before handing over the keys to the carts. She stated the nurse receiving the keys was responsible for the medications on their carts during their shift. She stated nurses and medication aids were never supposed to share keys with one another. She stated the counts were important to prevent drug diversions and ensure the resident's medications were available and accounted for. Unit Manager E stated LVN A had reported that LVN B had asked for her keys to retrieve an OTC medication and he loaned them to her. LVN A reported she noticed the medications were missing at the end of her shift while counting medications with the oncoming nurse. She stated LVN A reported the missing medications immediately and began searching for them. Unit Manager A stated she checked on Resident #1 herself and she had denied needing any medications and had been receiving her scheduled pain medications. She stated a facility-wide medication audit had been conducted and no other medications were missing. During an observation and interview with LVN A on 03/11/24 at 1:46 PM, she stated she had always counted controlled medications with the off-going nurse when she came on shift. She stated she counted her cart at the beginning of her shift and the counts were correct. She stated the day the incident occurred was a very busy shift. She recalled LVN B asking for her keys to retrieve a medication, she stated she could not recall the time but thought it was sometime around lunch. LVN A stated she was preoccupied that day and did not observe LVN B access her cart. She could not recall how long LVN B was in possession of her keys. LVN A stated she was counting the medications in her cart with the oncoming nurse at the end of her shift when she noticed Resident #1's Oxycodone tablets were missing. She stated she began searching through every medication in her cart and the other nurses were searching as well. She stated she immediately notified Unit Manager E and the DON. She stated she did not step away from her cart or give the keys to anyone until the DON arrived. LVN A stated she did not attempt to contact LVN B because she just wanted to focus on what she needed to do. She stated she, and other nearby nurses, searched every medication card in every cart and were unable to find the medications. She stated Resident #1 had never needed the medication on her shift as her scheduled pain medications usually controlled her pain. LVN A stated she knew she should have never handed her keys to anyone without counting the medications and she felt terrible about the mistake. She stated she had received training about it before and should have known better. She stated she had never had this happen to her before. She stated she was drug tested , written up and received additional training. LVN A stated the risk for sharing keys without counting medications were drug diversions which placed residents at risk for unrelieved pain due to not having their medications available. LVN A stated the correct procedure for handing over keys including counting every narcotic control sheet, every corresponding medication bubble pack card and every individual pill. Following the interview, LVN A demonstrated counting her cart with Unit Manager E. The controlled medication counts within her cart, including those belonging to Resident #1, were accurate. During a follow-up interview and observation on 03/11/24 at 2:15 PM, LVN B described the procedure for counting her cart at the end of her shift including counting narcotic control sheets, the individual medication cards and the individual tablets. LVN B was observed counting her cart with RN F prior to handing her keys over to him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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 - Few	During an interview with RN F on 3/11/24 at 4:35 PM, he stated he had received in-service training related to medication cart security. He stated he knew staff should never loan their keys to anyone and controlled medications always needed to be counted and cosigned prior to handing keys off or accepting keys from anyone. RN F stated he had never encountered an issue but knew if any discrepancy was found, the Unit Manager and DON should be notified immediately. RN F stated the risk of loaning keys to other staff included drug diversions, and residents may not be able to receive their medications when needed which would increase their pain and suffering. He stated drug diversions could also lead to legal ramifications for the nurse and the facility. In an interview on 03/11/24 at 5:10 PM, the Administrator stated he believed the cause of the drug diversion was the nurses failed to follow protocol by sharing keys. He stated LVN A had said she counted the cart before and after her shift. He stated he did not find enough evidence to assign direct blame as far as who removed the drugs because all involved denied taking the medications. He stated LVN A and LVN B had been suspended, both their drug screens were negative, the nurses were written up and re-educated prior to returning to work. The Administrator stated the risk for failing to follow protocol included failure of narcotic control by losing sight of the count. He stated the risk to residents included not having their medications available leading to increased pain and worsening of health conditions. The Administrator stated the Pharmacy Consultant assisted with the audit and had conducted the in-service training with all nurses and medication aides. He stated the DON and Unit Managers were responsible for monitoring the controlled medications and ensuring counts were conducted. Record review of an In-Service training Reports dated 2/15/24 from 3 pm to 11 pm and conducted by the DON and another dated 02/20/24, conducted by the Consultant Pharmacist and included the following: Drug Diversion Risk Reduction Policy (undated): Accountability-Controlled substance count is verified between on-coming nurse and off-going nurse each time the keys to lock box where controlled substances are stored are exchanged between licensed staff. (usually end of shift but may include lunch breaks and early departure from shift at times). Shift-shift count is performed as reconciling aloud the last name of resident, medication name, medication strength, and quantity remaining. Facility will perform routing audit of shift-shift count sheets and failure of staff to sign this form will result in disciplinary action as this document is maintained to show which nurse is directly responsible for the controlled substance inventory at all times per DEA regulations. Controlled substance emergency kit (unless Omnicell computerized drug dispensing machine]) will be counted to reconcile inventory qshift [sic] Record review of the facility's policy/procedure titled, Management of Controlled Medication and dated revised January 2024 reflected the following: Policy The Facility staff will follow the method of accounting for controlled medications through receiving, administration, storage, and destruction, which meets the requirements of the state and federal narcotic enforcement agencies. Procedure (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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 - Few	.Shift-to-Shift Count: 1. Controlled medications will be counted every shift change (scheduled or incidental) by an authorized staff member (RN/LVN/CMA) reporting on duty with an authorized staff member reporting off duty. a. Scheduled shift change = routine shift changes (8, 12, or 16 hours) b. Incidental shift change = interrupted routine shift due to any circumstances (staff illness, reassignments, partial shift work etc.) 2. At the end of every shift the authorized staff member reporting off duty meet at the designated medication cart or storage area to count controlled medications. 3. The authorized staff member reporting off duty reads all Controlled Drug Receipt/Record/Disposition Form[s] one at a time, announcing the Patient's name, the medication, and the dose. 4. The authorized staff member reporting on duty counts the amount of remaining controlled medications (bubble pack or bottle) and announces the number aloud . If a discrepancy is found: a. Check the Patient's order sheets, administration records and nurse's notes in the chart to see if a controlled medication has been administered and not recorded. b. Check previous recordings from the Controlled Drug Receipt/Record/Disposition Form for mistakes in arithmetic or error in transferring numbers from one sheet to the next. c. If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the Director of Nursing/designee IMMEDIATELY. d. The authorized staff member reporting off duty must remain in the facility during the investigation. e. Generate the appropriate incident statements. f. The Director of Nursing/designee will then contact the Administrator. The Administrator will determine if the incident is reportable (internal/external). The Consultant Pharmacist will be notified. Controlled medication key(s): a. Upon completion of tour of duty, the authorized staff member reporting off duty transfers the key(s) to the authorized staff member reporting on duty. b. The controlled medication key(s) will be in the possession of the authorized staff member during his/her shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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 - Few	c. The authorized staff member will have the key(s) in his/her possession at all times while on duty. The key(s) shall not be out of the possession of the authorized staff member. If another staff member must give medications, a complete count of the controlled medications must be performed. d. The controlled medication key(s) will not be given to private duty nurses or any nurse not assigned to that unit, or to physicians, nurses aides, or any staff who are not permitted to give medications.