

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Park Manor of the Woodlands		STREET ADDRESS, CITY, STATE, ZIP CODE 1014 Windsor Lake Boulevard The Woodlands, TX 77384	

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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644</p> <p>Based on observation, interview, 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 16% based on 4 errors out of 25 opportunities, which involved 1 of 8 residents (Resident #99) reviewed for medication errors.</p> <p>-The facility failed to ensure LVN N administered the correct dose of Potassium Chloride or Ferrous sulfate liquid to Resident #99 according to Physician orders.</p> <p>-The facility failed to ensure LVN N did not crush and administer; Acetaminophen ER (an extended-release formulation which should not be crushed) to Resident #99 via g-tube (a way to deliver liquid nutrition through a flexible tube to your digestive system) instead of Acetaminophen as ordered by the Physician.</p> <p>These failures could place residents at risk of inadequate therapeutic outcomes.</p> <p>Findings include:</p> <p>Record review of Resident #99's face sheet dated 8/8/24 revealed an [AGE] year-old female readmitted on [DATE]. Her diagnoses included gastrostomy status (a surgical procedure used to insert a tube through the abdomen and into the stomach.), type 2 diabetes, hypertension (high blood pressure), and cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain).</p> <p>Record review of Resident #99's admission MDS assessment dated [DATE] revealed her cognitive skills for daily decision making were severely impaired-never/rarely made decisions. She was dependent on staff for ADL care.</p> <p>Record review of Resident #99's care plan dated 7/11/24 revealed she had pain related to wounds and impaired mobility. Interventions were to administer pain medication as per MD orders.</p> <p>Record review of Resident #99's Physician Orders for August 2024 revealed the following orders:</p> <p>Acetaminophen 325 mg give 2 tablets via g-tube two times a day for pain, order date 7/12/24,</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ferrous Sulfate oral solution 220 (44 Fe) mg/5 mL give 5 mL via peg tube one time a day for anemia, order date 7/19/24,</p> <p>Potassium Chloride oral solution 20 mEq/15 mL give 15 mL via g-tube one time a day for supplement, order date 7/29/24.</p> <p>In an observation on 8/8/24 at 8:34 a.m. with LVN N revealed she prepared Resident #99's morning medications for administration. She prepared Acetaminophen ER 650 mg - 1 tablet, 10 mL of Ferrous Sulfate 220 mg/5 mL liquid, 11 mL of Potassium Chloride 10% 20 mEq/15 mL liquid, and six additional medications. She crushed the tablets including the Acetaminophen ER and administered all medications individually to Resident #99 via g-tube.</p> <p>In an observation and interview on 8/8/24 at 9:14 a.m. LVN N said she did not realize Resident #99's Ferrous sulfate and Potassium chloride liquid were not at the correct dosage and said she may have been nervous. She said when preparing liquid medications, she ensured she located the measurement, poured the appropriate amount, and verified the amount to ensure accuracy. She said it was important to administer the correct amount of medication to the resident because that was the amount ordered by the physician. She said she was not sure if the Acetaminophen ER could be crushed because the bottle did not specify that it could not be crushed. She said she did not originally see the acetaminophen 325 mg tablets on the nurse cart and instead administered one acetaminophen ER 650 mg tablet.</p> <p>In an interview on 8/8/24 at 10:11 a.m., the DON said acetaminophen ER and acetaminophen were not the same medication. She said the extended-release formulation could not be crushed because it was a slow-release medication.</p> <p>In an interview on 8/8/24 at 3:44 p.m. the Administrator said he expected a 0% medication error rate and for nursing staff to follow physician orders.</p> <p>Record review of the facility's Administering Medications policy dated December 2012 read in part, . Medications shall be administered in a safe and timely manner, and as prescribed . 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication .</p> <p>Record review of the facility's undated Do not crush list of medications form read in part, . Below is a list of the most common medications that shouldn't be crushed, cut, or chewed. Medications that have modified-release dosage forms or a special coating: Acetaminophen ER .</p>		