

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Remarkable Healthcare of Seguin		STREET ADDRESS, CITY, STATE, ZIP CODE 1339 Eastwood Dr Seguin, TX 78155	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys (the Medication Cart) for 1 medication cart out of 3 medication cart's reviewed for medication storage.</p> <p>The facility failed to ensure medications were secured on medication cart # 2</p> <p>The non-compliance was identified as past non-compliance. The noncompliance began on 10/3/2024 and ended on 10/5/23. The facility had corrected the non-compliance before the survey began.</p> <p>This deficient practice could place residents at risk of medication misuse or drug diversion.</p> <p>The findings were:</p> <p>Record review of Resident # 1 face sheet dated 11/13/24 , revealed an [AGE] year old male admitted to the facility on [DATE] with diagnosis that included: Congestive heart failure,(is a long-term condition in which your heart can't pump blood well enough to meet your body's needs) , Osteoarthritis (condition in which the cushions at the ends of the bones wears down over time and type II diabetes (condition that happens because of a problem in the way body regulates and uses sugar as fuel).</p> <p>Record review of Resident's # 1 Quarterly MDS assessment dated [DATE] reflected a BIMS score left blank which indicated Resident # 1 was unable to complete the interview.</p> <p>Record review of Resident's # 1 monthly physician orders for November 2024, revealed an order for Norco oral tablet 10-325 mg administer one tablet by mouth three times a day at 0500, 1300 and 2000.</p> <p>Record review of Resident # 1 pain assessment for 10/3/24, revealed he was not in any pain and was given Tylenol 325 mg two tabs at 0515 a.m.</p> <p>In an interview with Resident # 1 on 11/13/24 at 8:35 a.m., revealed he was not in any pain on 10/3/24 when his medication Norco 10-325 mg went missing and he was glad that the facility was able to get replacement pain medication promptly on 10/3/2024 for his 1300 dose.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with RN A on November 13, 2024, at 9:10 AM, she reported that the Norco oral tablet (10-325 mg) count for Resident #1 was accurate when she started her shift on October 3, 2024, at 10:00 p.m., RN A mentioned that she left the medication cart keys unattended in her coat at the nursing station for an unspecified period. Additionally, she stated that at 5:00 AM on October 3, 2024, she could not locate approximately forty Norco oral tablets (10-325 mg) in the medication cart and the narcotic sheet , this was when RN A contacted the DON .</p> <p>In an Interview with the DON on 11/13/24 at 9:28 a.m., she stated that on 10/3/2024 at approximately 5:15 am RN A called her to notify that 40 Norco (10-325 mg) and narcotic sheet were missing from medication cart. The DON called the police and filed a report, nurses on shift were drug tested , and it was determined that RN A left keys unattended which led to the missing Norco (10-325 mg).</p> <p>Record review of inservice dated 10/03/2024 revealed inservice to all nursing staff on medication storage to include securing narcotic keys prior to survey entrance.</p> <p>During staff interviews on 11/13/2024 at 7:35 a.m., with three LVN's and two RN's from all shifts staff stated they had been in-serviced on ensuring keys were with the nurse at all times.</p> <p>Observation on 11/12/24 at 2:00 p.m, revealed that licensed nurses were appropriately securing keys and upon rounds and all the medication carts in building were appropriately locked and secured.</p> <p>Record review of the facility policy Storage of Medications, revised December 2010, reflected only persons authorized to prepare and administer medications shall have access to the medication room, including keys .</p> <p>The non-compliance was identified as past non-compliance. The noncompliance began on 10/3/2024 and ended on 10/5/23. The facility had corrected the non-compliance before the survey began.</p>		