STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676282	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayou Manor	4141 S Braeswood Blvd Houston, TX 77025

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** 41392 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 4 residents (Resident #26) reviewed for pharmacy services. The facility failed to administer the physician prescribed decreased dose of Amlodipine (a medication used to lower blood pressure) for Resident #26's peripheral edema (swelling of lower legs or hands). This failure could place residents at risk of unwanted side effects and inadequate therapeutic outcomes. Findings include: Record review of Resident #26's face sheet, dated 08/15/2024, reflected an [AGE] year-old who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included spontaneous bleeding in the brain, paralysis affecting right dominant side, stroke, imbalance of blood cholesterol, buildup of fluid around the brain, difficulty speaking and Hypertension (elevated blood pressure). Record review of Resident #26's Physician's Progress Note, date of service 6/17/2024, reflected a diagnosis which included diabetes. Record review of Resident #26's quarterly MDS (a Resident Assessment and Care Screening tool) dated 05/09/2024, reflected a BIMS score of 00 out of 15 ,which indicated severe cognitive impairment. Resident #26 had impairment to one side of the upper extremity and impairment to both sides of the lower extremity. Resident #26 was dependent on staff assistance for all ADLs. Resident #26 had an abdominal feeding tube. Record review of Resident #26's care plan reflected the resident had an ADL self-care performance deficit r/t Stroke with weakness affecting the right dominant side, date initiated was 02/13/2024. The resident had hypertension; date initiated was 2/13/2024. Interventions included to give anti-hypertensive medications as ordered. Monitor for and document any edema and notify MD. (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #26's active orders as of 08/15/2024 reflected an order for Amlodipine 5mg, give one tablet via Gastrostomy tube or G-tube (feeding tube inserted into the abdomen) one time a day for Hypertension, dose decreased due to peripheral edema, date ordered 08/14/24 and start date was 08/15/24. Record review of Resident #26's MAR for August 2024 reflected, LVN A documented the administration of Amlodipine 5mg tablet on 08/14/2024 at 8:00 AM. Further review reflected Amlodipine 10mg tablet was started on date 02/01/2024 and discontinued on 08/14/2024. In an observation and interview on 08/15/2024 at 6:50 AM, Resident #26 was alert but did not speak. The head of the bed was elevated. Resident #26's hands, fingers and lower arms were swollen, and her fists were softly clenched. LVN A washed her hands, donned (put on) PPE. LVN A checked Resident #26's blood sugar, it was 193. LVN A checked Resident #26's blood pressure and it was 147/55, with a pulse of 102. LVN A removed the PPE and performed hand hygiene. LVN A prepared Resident #26's medications. LVN A sanitized her hands and placed each of the following medications into individual medicine cups: Amlodipine 10mg tablet, Fenofibrate 145mg tablet, Lisinopril 10mg tablet, Metoprolol 50mg tablet, Famotidine 20mg tablet and potassium chloride 20meq powder packet. LVN A crushed each tablet individually and prepared the NPH (Neutral Protamine [NAME]) insulin (a type of insulin which regulates the amount of glucose in the blood). LVN A washed her hands at the sink and donned PPE. LVN A added 10ml of warmed water from the faucet to each medication cup and added 120ml of water to the cup with the potassium chloride powder. LVN A disconnected the feeding tube from the G-tube and checked Resident #26's G-tube for placement using the stethoscope then checked for residual. There was zero residual. LVN A attached the 60ml syringe barrel to the end of G-tube and poured 30ml of water to flush via gravity. LVN A poured medication from the first cup into the syringe barrel, followed by 10ml of water and repeated the process with the remaining medications. After all medications were infused, LVN A poured 30ml of water to flush and closed the end of the G-tube. LVN A stated she would not connect the tube feeding d/t it was time for the resident to have bowel rest for 4 hours. LVN A removed gloves, performed hand hygiene, donned clean gloves, cleansed Resident #26's skin on the abdomen and administered 12units of NPH insulin to Resident #26's lower right quadrant. In an interview on 08/15/2024 at 10:00 AM, LVN A stated she missed correctly reading the dose for Resident #26's Amlodipine. LVN A stated she should have given 5mg of Amlodipine instead of 10mg. LVN A stated the order was changed yesterday (8/14/2024) d/t peripheral edema. LVN A stated the risk to Resident #26 was edema if the ordered dose was not given. LVN A stated her last in-service on Medication Administration was about one month ago. LVN A stated when she administered medications she should check for the right person, right medication, right dose, this time she did not see the right dose and she should check for the right time. LVN A stated she would let the DON know of the medication error. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/15/2024 at 10:15 AM, the DON stated she expected the nurses to be looking at the physician order, compare the blister pack to the MAR, if the medication required a blood pressure, then it should be explained to the resident and then the nurse would sign for the medication. The DON stated she would start a medication error report. The DON stated she instructed LVN A to notify the MD and RP and to always check the MAR when administering a medication. When asked what the risks were to the resident, the DON stated she did not have the lab results in front of her but assumed the labs were better than what they were, and the MD wanted to reduce the dose of the Amlodipine. When asked how she ensured the nurses and medication aides were administering medications per policy and procedures, the DON stated she conducted end of the month in-services for reminders on medication pass, which included to make sure they told the alert residents what medications they were given. Record review of the facility's policy on Administering Medications through an Enteral Tube, revised April 2007, read in part: The purpose of this procedure provide guidelines for the safe administration of oral medications .General Guidelines, follow the medication administration guidelines in the policy entitled Administering Medications .Steps in the Procedure .6. Check the label on the medication and confirm the medication name and dose with the MAR. 7. Check the expiration date on the medication .8. Check the medication dose. RE-check to confirm the proper dose