

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 900 College Ave Borger, TX 79007	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the right to be free from misappropriation of property for 1 (Resident #1) of 8 residents reviewed for misappropriation of property.</p> <p>The facility failed to prevent a diversion (misappropriation) of Resident #1's Tylenol #3 tablets (used to treat pain) for a total of 10 tablets.</p> <p>This failure could place residents at risk for decreased quality of life, misappropriation of property, increased/uncontrolled pain, and dignity.</p> <p>Findings include:</p> <p>Record review of Resident #1's clinical record revealed an [AGE] year-old female resident admitted to the facility originally on 09/25/2019 and readmitted on [DATE] with diagnoses to include malignant neoplasm of unspecified site of the right female breast (a fast-growing cancer of the breast that spreads to other areas of the body), polyneuropathy (a generalized term for peripheral nervous system disorders that impact nerve function in multiple areas of the body), osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), gout (a disease in which defective metabolism of uric acid causes arthritis, especially in the smaller bones of the feet, deposit of chalkstones (a chalky deposit of sedum urate sometimes occurring in the joints of person affected by gout), and episodes of acute pain, and restless leg syndrome (a nervous system problem that causes you to feel an unstoppable urge to get up and pace or walk).</p> <p>Record review of Resident #1's clinical record revealed her last MDS was a quarterly completed 04/08/2025 listing a BIMS score of 11 indicating she was moderately cognitively impaired, and she had a functionality of requiring set-up/clean up assistance for most of her activities of daily living. Resident #1 was listed as having pain Occasionally, that affected her sleep Occasionally, that interfered with therapy activities Occasionally, and interfered with her day-to-day activities Occasionally.</p> <p>Record review of Resident #1's Medication Administration Report with Schedule for April 2025 revealed the following order:</p> <p>- Acetaminophen-Codeine Oral Tablet 300-30 MG (Acetaminophen w/ Codeine) Give 1 tablet by mouth every 6 hours as needed for Pain -D/C Date- 04/24/2025. (Tylenol #3)</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's clinical record revealed a care plan with the admitted [DATE], which revealed the following:</p> <p>Focus: The resident has a potential for pain r/t osteoarthritis and is on pain medication.</p> <p>Date Initiated: 07/12/2022.</p> <p>Revision on: 04/21/2025</p> <p>Interventions/Tasks: Administer analgesic medication as per orders. Give 1/2 hour before treatments or care.</p> <p>Date Initiated: 07/12/2022.</p> <p>Revision on: 07/12/2022.</p> <p>During an observation and interview on 4/25/2025 at 10:06 AM Resident #1 was in her room sitting in her recliner wearing her oxygen. Resident #1 reported that she had no issues with her medications and that she was not aware of any missing medications because she has not missed any doses. Resident #1 appeared in good condition, relaxed, and comfortable.</p> <p>During an interview on 04/25/2025 at 08:53 AM LVN A (the witness who discovered the drug diversion incident) reported that she received a call from Hospice for Resident #1 on Thursday 04/17/2025 for a narcotic count and she gave Hospice the information that Resident #1 had 13 Tylenol #3 pills left. LVN A then received another call when she was off on Saturday 04/20/2025 to verify that she had reported a count of 13 Tylenol #3 pills on Thursday 04/17/2025. LVN A reported that this was all she knew of the event in question.</p> <p>During an interview on 4/25/2025 at 01:44 PM the DON reported that the nurse who should have discovered the missing medications for Resident #1 had been suspended and has been tested for narcotics, but the results are still pending. The DON reported that Resident #1's Tylenol #3's medication card was filled on 03/06/2025 for 30 pills and according to the MAR, Resident #1 was given 20 pills, so it looks like 10 pills were unaccounted for. The DON reported that due to the Narcotic count sheet and the Narcotic Medication Blister Pack/Card were both missing, she was not able to exactly identify/make sure what happened. The DON reported that Resident #1 did not miss any doses of her Tylenol #3, that they had the medication in the e-kit and they were able to cover what was needed until Hospice could refill the prescription. The DON reported that only one dose of Tylenol #3 was needed from the E-Kit. The DON reported that nursing staff were immediately in-serviced on training for medication administration records and narcotic counts. The DON reported that if a medication was mishandled or disappears like this one apparently has then a nurse could have misappropriated the resident's medication, that it could affect the resident if they could not get that medication replaced immediately.</p> <p>During an interview on 4/25/2025 at 02:18 PM LVN A (the witness who discovered the drug diversion incident) reported that if resident medications were to disappear then that could be an issue that could affect the resident in which they would not get the treatment they were supposed to and that could make their condition worse.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility provided training dated 04/19/25 revealed the following:</p> <p>Signing out PRN's must be done in the Narcotic book and in the computer. You will sign out and count every time you give your cart to next shift or at lunch. This includes med passes as well. A completed Narc sheets to be sent to the DON via under her door or in box immediately. Do not take important nursing documents including report sheets, Narc sheet to hall 200. - signed by 22 nursing staff.</p> <p>Record review of the facility provided training dated 04/22/25 revealed the following:</p> <p>Second signature for signing med in, wasting meds. Sign your count sheets and sign in sheets for Narcs. - Signed by 15 nursing staff.</p> <p>Record review of the facility provided policy titled Abuse/Neglect revised 09/09/2024, revealed the following:</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property .</p> <p>9. Misappropriation of resident property: means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident belonging or money without the resident consent.</p>