

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/10/2025
NAME OF PROVIDER OR SUPPLIER  Bridgecrest Rehabilitation Suites		STREET ADDRESS, CITY, STATE, ZIP CODE  14100 Karissa Court Houston, TX 77049	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38644</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for 1 of 2 residents (Resident #1) reviewed for pharmacy services.</p> <p>MA K attempted to administer Resident #23's Hydrochlorothiazide (used to treat high blood pressure and fluid retention) to Resident #1 instead of Hydralazine (used to lower blood pressure and improve blood flow) as ordered by the MD.</p> <p>This failure could place residents at risk of medication errors resulting in exacerbation or deterioration in health conditions.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet revealed a [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnoses included hyperkalemia (high potassium), hypertension (high blood pressure), and pulmonary heart disease.</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. She required assistance from staff with ADL care.</p> <p>Record review of Resident #1's care plan edited 2/7/25 revealed she was at risk for signs and symptoms of hyper/hypotension related to diagnosis of hypertension. Nifedipine (medication used to treat high blood pressure and angina), carvedilol (medication used to treat heart failure, hypertension, and heart attack) as ordered. The approach was to administer medications as ordered.</p> <p>Record review of Resident #1's Physician Orders for February 2025 revealed an order for Hydralazine 25 mg give 75 mg every 6 hours, order date 11/9/24.</p> <p>Record review of Resident #1's MAR dated 1/26/25 - 2/8/25 revealed Hydralazine 25 mg give 3 tablets for hypertension was scheduled 4 times a day at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m.</p> <p>In an interview on 2/8/25 at 2:29 p.m., Resident #1 said she received Hydralazine every 6 hours but did not receive the medication on some shifts.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation and interview on 2/8/25 at 5:02 p.m., MA K began medication administration for Resident #1. She retrieved Resident #23's Hydrochlorothiazide 25 mg from the cart and placed 3 tablets in the medication cup. MA K locked the medication cart and entered Resident #1's room. This Surveyor intervened and asked MA K to return to the medication cart to verify the medication. Observation revealed the medication in the cup (Resident #23's Hydrochlorothiazide) did not match the medication in Resident #1's blister pack (Hydralazine). MA K said she could not read the imprint on the tablet and said she may have grabbed the wrong blister pack. She said the blister pack was in the wrong spot and the medication she prepared for Resident #1 belonged to Resident #23. She destroyed Resident #23's Hydrochlorothiazide and prepared Hydralazine 25 mg 3 tablets and administered it to Resident #1.</p> <p>In an interview on 2/8/25 at 5:19 p.m., MA K said she checked the MAR and blister pack to verify the correct amount, dosage, and time. She said she reviewed the medication name and the dosage and thought it matched. She said she noticed it was a different medication when the Surveyor said something. She said she must have placed Resident #23's medication in Resident #1's spot on the medication cart. She said Hydralazine was for Resident #1's blood pressure.</p> <p>In an interview on 2/8/25 at 5:24 p.m., the DON said nursing staff should follow the rights of medication administration which included verifying the right patient and to compare the MAR to what was on hand. She said (Hydralazine) was a blood pressure medication and (Hydrochlorothiazide) was a diuretic (used to increase urine production and help lower blood pressure and fluid retention). She said the risk included medication error, and it could be detrimental.</p> <p>Record review of the facility's Medication Management policy dated 4/7/24 read in part, .The staff and practitioners shall strive to minimize potential for medication error by: A. Following the :8 Rights for administering medication: 1. The right patient/resident, 2. The right drug .</p>