

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Hollymead		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 Long Prairie Road Flower Mound, TX 75028	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of five residents reviewed for medications.</p> <p>-The facility failed to have Resident #1's Hydromorphone (used to manage pain) available for administration, which caused the resident to miss two doses.</p> <p>This failure could place residents at risk of not receiving their medication treatment(s) as ordered by the physician to receive the full therapeutic benefit.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 4/30/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: unspecified pain, schizoaffective disorder (mood disorder), type II diabetes, epilepsy (seizure disorder), kidney failure, hypertension (high blood pressure), edema (swelling caused by trapped fluid in tissue), and heart failure.</p> <p>Record review of Resident #1's quarterly MDS Assessment, dated 4/10/24, reflected the resident was cognitively intact with a BIMs score of 15. Further review reflected Resident #1 required moderate assistance or supervision with most ADLs.</p> <p>Record review of Resident #1's care plan, dated 8/2/23, reflected the resident had a problem with pain management with interventions that included screen/assess for pain on admission and daily, obtain pain management history from resident to target prior experiences, assess resident's knowledge of side effects and safety precautions related to use of pain medication and nonpharmacologic measures, assess the resident's ability to use pain reporting scale, assess for change in bowel habits, resident will participate in making choices regarding pain management, observe for behaviors that indicate pain, and instruct resident in pain medication regimen.</p> <p>Review of Resident #1's active order summary, dated 8/3/23, reflected the resident was ordered the following medications for pain:</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>-Hydromorphone 2mg tablet every 8 hours (12AM, 8AM, 4PM)</p> <p>-OxyContin 10mg tablet every 12 hours.</p> <p>Record review of Resident #1's MAR for April 2024, reflected, the resident's Hydromorphone was not administered on 04/29/24 at 12:00 AM or 8:00 AM. LVN C coded the MAR as not completed at 12:00 AM and LVN A coded the MAR as not completed at 8:00 AM.</p> <p>Record review of Resident #1's controlled drug receipt/record/disposition form reflected Hydromorphone 2mg (90 tablets) was received at the facility on 4/29/24 and the first dose was signed out by RN B on 4/29/24 at 6:30 PM.</p> <p>In an interview on 4/30/24 at 1:23 PM, the DON stated she had not been made aware of any medication issues in about 2 months until Resident #1 recently spoke to her about concerns with the facility running out of her pain medication. The DON stated staff attempted to get Resident #1's Hydromorphone refilled last Thursday (4/25/24) and the pharmacy reported it was too early. The DON stated the MD sent in the prescription on 4/29/24 and the Hydromorphone was received at the facility on the same day. The DON stated Resident #1 did not miss any doses of the medication to her knowledge.</p> <p>In an interview on 4/30/24 at 1:50 PM, LVN A stated she worked at the facility for about a week. LVN A stated she worked with Resident #1 on 4/29/24, 6:00 AM-2:00 PM. LVN A stated at the start of her shift, Resident #1 informed her that she was out of Hydromorphone. LVN A stated she notified the MD immediately and showed Resident #1 the message to reassure her that it was being taken care of. LVN A stated Resident #1 was upset about not having her medication; however, the resident did not report feeling extreme pain or being unwell. LVN A stated Resident #1 had Oxycontin available for pain. LVN A stated the medication had not arrived at the facility by the end of her shift at 2:00 PM.</p> <p>In an interview on 4/30/24 at 2:00 PM, the Regional Nurse stated insurance companies made it difficult to get pain medications, which sometimes caused the facility to run out before the MD could submit a new prescription. The Regional Nurse stated the medication packs had a section marked off for the reorder period and staff knew to notify the MD at that point; however, the insurance company determined when the prescription could be filled. The Regional Nurse stated the expectation was for staff to monitor the medications closely and communicate with the DON and MD when medications were getting low or any issues with reordering to prevent the facility from not having the medication available to administer as ordered.</p> <p>In an interview on 4/30/24 at 2:48 PM, the MD stated he received a message from staff one day last week informing that Resident #1's Hydromorphone needed to be refilled. The MD stated he had written a prescription for a 30-day supply that ended on 4/28/24. The MD stated the insurance company would not allow a new prescription for the Hydromorphone to be written prior to 4/28/24, so he sent in a new prescription on 4/29/24. The MD stated the primary concern for a resident missing doses of a medication like Hydromorphone would be withdrawal symptoms; however, he did not have concerns for Resident #1 missing 2 doses. The MD stated Resident #1 also had an order for Oxycontin that was administered for pain, and although the pain management may not have been as optimal, it was being treated.</p> <p>(continued on next page)</p>		

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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 interview on 4/30/24 at 3:02 PM, the VP of Pharmacy Operations stated the FDA was strict on controlled substance to minimize the risk of misuse and diversion. The VP of Pharmacy Operations stated Resident #1's insurance company would reject a prescription for her Hydromorphone if it was submitted more than two days from last dispense day. The VP of Pharmacy Operation stated the prescription's last dispense day was on 4/28/24, so it could have been reordered on 4/26/24. The VP of Pharmacy Operation stated the pharmacy was a 7-day operation and the facility could have reordered the medication even over the weekend, and a STAT request would get the medication to the facility within 4 hours.</p> <p>In an interview on 4/30/24 at 3:37 PM, RN B stated she worked at the facility for about 6 months, 2:00 PM-10:00 PM. RN B stated she worked on 4/29/24 with Resident #1. RN B stated she was the receiving nurse when Resident #1's Hydromorphone arrived at the facility around 6:00 PM. RN B stated she checked the medication to make sure it matched the MD orders and signed off for it. RN B stated she immediately administered Resident #1's evening dose. RN B stated Resident #1 had complained about not having her medication; however, she did not report having diarrhea or exhibit other signs of withdrawal or being in excruciating pain.</p> <p>In an interview on 4/30/24 at 3:45 PM, LVN C stated she worked PRN for the facility and had only worked about 10 shifts. LVN C stated she worked 10:00 PM-6:00 AM. She stated she worked overnight on 4/28/24 with Resident #1. LVN C stated there was no Hydromorphone available in the facility to administer to Resident #1 for her 12AM dose. LVN C stated Resident #1 was asleep when the Hydromorphone was due, and she did not wake up in pain or to ask for the medication. LVN C stated she did not notify anyone that the medication was out because she thought it was the ADON or DON's responsibility to reorder controlled medications.</p> <p>In an interview on 4/30/24 at 4:42 PM, the DON stated the expectation was for her nurses to reorder all meds at least 7 days in advance. The DON stated if the insurance company required a smaller window to reorder meds, she would still expect her nurses to notify the MD and DON 7 days in advance and it would be the responsibility of the MD, ADON, and DON to follow up with the pharmacy. The DON stated the risk of running out of pain medication is that the resident could experience pain.</p> <p>In an interview on 4/30/24 at 4:55 PM, CNA D stated she worked for the facility for a month, first shift. She stated she worked with Resident #1 on 4/29/24 and the resident seemed fine. CNA D stated Resident #1 did not report having diarrhea, being in pain, or feeling ill. She stated Resident #1 was eating and acting like her normal self.</p> <p>A facility policy on medication ordering/refills was requested on 04/30/24 and the Regional Nurse stated the facility did not have one.</p>		