

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2024
NAME OF PROVIDER OR SUPPLIER Park Manor Bee Cave		STREET ADDRESS, CITY, STATE, ZIP CODE 14058 Bee Caves Parkway, Bldg B Bee Cave, TX 78738	
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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to ensure that pain management was provided to a resident who required such services, consistent with professional standards of practice for two (Resident #1 and Resident #2) of four residents reviewed for pain. The facility failed to provide effective pain management for Residents #1 and #2 as they went multiple days without their pain medication leaving them in excruciating pain. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 07/19/24 at 3:00 PM. While the IJ was removed on 07/21/24 at 12:50 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk for prolonged and unnecessary pain and suffering and a decreased quality of life. Findings included: Resident #1 Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including major depressive disorder, anxiety disorder, muscle wasting and atrophy (wasting away), and chronic pain syndrome. Review of Resident #1's quarterly MDS assessment, dated 04/26/24, reflected a BIMS of 15, indicating she was cognitively intact. Section J (Health Conditions) reflected she received a scheduled and PRN pain medication regimen and was frequently in pain. Review of Resident #1's quarterly care plan, dated 07/01/24, reflected she was currently prescribed an opioid medication for her history of pain with an intervention of administering opioids as prescribed. Review of Resident #1's physician order, dated 06/06/24, reflected Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676373	Facility ID: 676373 If continuation sheet Page 1 of 12

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Mar, July 2024, reflected from 07/05/24 - 07/07/24 she missed five doses due to the medication being unavailable. From 07/14/24 - 07/17/24 she missed 11 consecutive doses due to the medication being unavailable. Review of Resident #1's documented pain scale from 07/05/24 - 07/07/24 reflected her highest rating was a 7. Review of Resident #1's documented pain scale from 07/14/24 - 07/17/24 reflected her highest rating was a 10. Review of Resident #1's progress notes, dated 07/05/24 at 3:25 AM and documented by LVN A, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . Medication unavailable. Last Pill taken 7/5/24 at 10:00 PM. Nurse on duty does not have pyxis (emergency kit) access. Review of Resident #1's progress notes, dated 07/06/24 at 9:50 AM and documented by LVN A, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablets by mouth four times a day for chronic pain . not available. Review of Resident #1's progress notes, dated 07/07/24 at 2:44 PM and documented by LVN B, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . waiting for pharmacy. Review of Resident #1's progress notes, dated 07/14/24 at 11:28 PM and documented by LVN C, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . medicine reorder- and stated in 24-hour report. Review of Resident #1's progress notes, dated 07/15/24 at 4:56 PM and documented by LVN D, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . Medication not available to administer. Medication has been reordered by previous nurse. Review of Resident #1's progress notes, dated 07/16/24 at 5:40 AM and documented by LVN E, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . Waiting for pharmacy to deliver. (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's progress notes, dated 07/16/24 at 10:09 AM and documented by the ADON, reflected the following: This nurse was notified by [Resident #1] that her oxycodone-acetaminophen was out of stock. This nurse asked CMA who informed that they did not in-fact have her routine oxycodone-acetaminophen. This nurse called NP to inform medication was out and triplicate needed to be sent. NP informed this nurse that triplicate was sent day prior. This nurse called pharmacy. Pharmacy stated triplicate not showing on their end. Re-called NP to make aware. This nurse informed script would be re-sent . Medication placed on hold until received. During a telephone interview on 07/19/24 at 11:26 AM, LVN E stated LVN D informed him at shift-change on 07/16/24 that Resident #1 was out of her oxycodone but she had re-ordered it and would come in by that night. He stated he waited but it never came. He stated he did not reach out to the pharmacy or NP. He stated Resident #1 was in pain but she did sleep that night. During a telephone interview on 07/19/24 at 1:20 PM, LVN B stated she was not sure what happened with Resident #1's oxycodone (at the beginning of July) but it was not reordered on time. She stated she was informed that another nurse had reordered it. She stated she believed it arrived on her shift and the resident was administered the medication. She stated when a resident is running low on any medication it should be reordered at least a week in advance. During a telephone interview on 07/19/24 at 2:12 PM, LVN C stated she could not remember what happened with Resident #1's medication on 07/14/24. She stated Resident #1 had run out of her pain medications a few times on different occasions. She stated during the week, staff do not order medications and it was often not there for the weekend shift. She stated Resident #1 was in continuous pain and could not miss a dose. She stated she did not reach out to the NP or the pharmacy. During a telephone interview on 07/19/24 at 2:00 PM, LVN D stated she did receive information regarding Resident #1's pain medication in the 24-hour report but she was shadowing a nurse and she was not her patient. She stated she remembered Resident #1 was asking for her pain mediation and other nurses were saying they were trying to reorder but there was an issue. She stated she did not reach out to the NP or pharmacy. Resident #2 Review of Resident #2's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, muscle wasting and atrophy, and pain. Review of Resident #2's quarterly MDS assessment, dated 07/03/24, reflected a BIMS of 4, indicating a severe cognitive impairment. Section J (Health Conditions) reflected she received a scheduled and PRN pain medication regimen and was frequently in pain. Review of Resident #2's quarterly care plan, dated 05/08/24, reflected she had chronic pain and was on pain management related to chronic physical disability with an intervention of monitoring/reporting to nurse complaints of pain or requests for pain treatment. (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's physician order, dated 06/01/24, reflected Fentanyl Transdermal Patch - 72-hour 37.5 MCG/HR - apply 1 patch trans dermally every 72 hours for chronic pain and remove per schedule. Review of Resident #2's MAR, July 2024, reflected she went without a fentanyl patch from 07/07/24 - 07/10/24 and on 07/16/24 due to none being available. Review of Resident #2's documented pain scale from 07/07/24 - 07/10/24 and on 07/16/24 reflected her highest rating was an 8. Review of Resident #2's progress notes, dated 07/07/24 at 1:09 PM and documented by RN F, reflected the following: This nurse reports that the time of completing the patch change, he notices that there is no stock to make the change, he proceeds to call the pharmacy . Review of Resident #2's progress notes, dated 07/07/24 at 4:55 PM and documented by RN F, reflected the following: Fentanyl Transdermal Patch 72-hour 37.5 MCG/HR - Apply 1 patch trans dermally every 72 hours for chronic and pain and remove per schedule. This nurse cannot comply with this indication today due to the lack of medication . During a telephone interview on 07/19/24 at 11:30 AM, RN F stated when he went to change Resident #2's fentanyl patch on 07/07/24, there were not any available patches in the cart. He stated he notified the DON and stated to move the order until the next morning and wait for the pharmacy to deliver it. He stated the resident was complaining of pain and he did administer a PRN Tramadol . He stated he did not contact the NP at this time. During an interview on 07/19/24 at 12:04 PM, Resident #1 and #2's NP stated sometimes she was given ample time for medication refill requests from staff and sometimes she was not. She stated sometimes she was made aware of residents going without medications after the fact. She stated she was not aware Resident #1 or #2 went a long period of time without pain medication. She stated if she had known, it would have been handled sooner. She stated the ADON asked her to put Resident #2's fentanyl patch on hold until a new one was delivered and was not sure why it was not put on her until 07/10/24. She stated the nurse could have easily put in a new order to restart the patch. She stated she was in the facility on 07/16/24 when Resident #1 sought her out, was very tearful, and was in moderate/severe pain. She stated she had not been notified by staff that she had been out of her pain medication for several days. She stated Resident#1 had chronic pain and should not miss any doses. She stated she was not always notified in a timely manner and would prefer to be notified of refill requests at least three days in advance. During an interview on 07/19/24 at 1:42 PM, the DON stated it was not her expectations for residents to go multiple days without their pain medications. She stated she expected nurses to re-order medications when there were seven days remaining. She stated it was all of the clinical staff's responsibility this was getting done. She stated a negative outcome of not reordering pain medications in a timely manner was increased pain, could lead to falls, or withdrawals. (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Pain Recognition and Management Policy, revised 12/2023, reflected the following: Policy: It is the policy of this to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan, and the residents' goals and preferences. .3. Management .c. If the pain management program is not effective, the licensed nurse will contact the resident's physician. The ADM was notified on 07/19/24 at 3:00 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 07/20/24 at 6:52 PM: F697: Pain Management: The notification of Immediate Jeopardy states as follows: On 7/19/2024, the facility failed to administer narcotic medication to resident # 1 and #2. 1. Medical Director was notified of the IJ on 7/19/24 at 4:55pm. The Pharmacist was notified of the IJ on 7/19/2024 at 4:58pm. 2. Resident #1 and #2 had pain assessments completed and medication audited on 7/19/2024 by a sister facility DON. 3. 100% audit of every MAR/TAR for pain triggers and that appropriate interventions were completed by a sister facility DON. If pain triggers are noted the auditing nurse will ensure that the appropriate pain meds are available and administered per MD orders or notify the MD to obtain any needed additional orders and ensure the patient is reassessed immediately by the nursing staff and pain is no longer triggering in the assessment. 4. 100% audit that all ordered pain medications are in house, and facility has minimum seven-day supply. Any needed re-orders were initiated on 7/19/24 by a sister facility DON. Pain medications are stored on nursing and CMA carts and in the e-kits. If a pain medication is not available CMA's are to notify the charge nurse and licensed nurses are to notify the MD or NP immediately. 5. In-servicing began on 7/19/2024 for Licensed Nurses and CMA's to include reordering of medications and what to do if a medication is not available and will be completed by 7/20/2024 by DON or designee. Any Nurse or CMA who has not received the in-service will not be allowed to work until in-service has been completed. Any agency, PRN or new CMA or licensed nurse will be in-serviced prior to their shift. In-service completed by DON/Designee. The DON was in-serviced and quizzed by regional consultant on 7/19/24 via phone. The staffing schedule will be assessed daily prior to each shift by the ED/DON or designee to ensure compliance. All staff will be in-serviced regarding the process of re-ordering pain medications and signs and symptoms of pain in residents upon hire, annually, and as needed by administrator/DON/designee starting on 7/19/24 and will be ongoing. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 42949 Based on observation, interview, and record review, the facility did not provide pharmaceutical services to meet the needs of each resident for two (Resident #1 and Resident #2) of four residents reviewed for pharmaceutical services. The facility failed to ensure Residents #1 and #2's pain medication was ordered in a timely manner. On several occasions they went without their pain medication subsequently leaving them in excruciating pain. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 07/19/24 at 3:00 PM. While the IJ was removed on 07/21/24 at 12:50 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk for prolonged and unnecessary pain and suffering and a decreased quality of life. Findings included: Resident #1 Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including major depressive disorder, anxiety disorder, muscle wasting and atrophy (wasting away), and chronic pain syndrome. Review of Resident #1's quarterly MDS assessment, dated 04/26/24, reflected a BIMS of 15, indicating she was cognitively intact. Section J (Health Conditions) reflected she received a scheduled and PRN pain medication regimen and was frequently in pain. Review of Resident #1's quarterly care plan, dated 07/01/24, reflected she was currently prescribed an opioid medication for her history of pain with an intervention of administering opioids as prescribed. Review of Resident #1's physician order, dated 06/06/24, reflected Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain. Review of Resident #1's Mar, July 2024, reflected from 07/05/24 - 07/07/24 she missed five doses due to the medication being unavailable. From 07/14/24 - 07/17/24 she missed 11 consecutive doses due to the medication being unavailable. Review of Resident #1's documented pain scale from 07/05/24 - 07/07/24 reflected her highest rating was a 7. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's documented pain scale from 07/14/24 - 07/17/24 reflected her highest rating was a 10. Review of Resident #1's progress notes, dated 07/05/24 at 3:25 AM and documented by LVN A, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . Medication unavailable. Last Pill taken 7/5/24 at 10:00 PM. Nurse on duty does not have pyxis (emergency kit) access. Review of Resident #1's progress notes, dated 07/06/24 at 9:50 AM and documented by LVN A, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablets by mouth four times a day for chronic pain . not available. Review of Resident #1's progress notes, dated 07/07/24 at 2:44 PM and documented by LVN B, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . waiting for pharmacy. Review of Resident #1's progress notes, dated 07/14/24 at 11:28 PM and documented by LVN C, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . medicine reorder- and stated in 24-hour report. Review of Resident #1's progress notes, dated 07/15/24 at 4:56 PM and documented by LVN D, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . Medication not available to administer. Medication has been reordered by previous nurse. Review of Resident #1's progress notes, dated 07/16/24 at 5:40 AM and documented by LVN E, reflected the following: Oxycodone-Acetaminophen Oral Tablet 10-325 MG - Give 2 tablet by mouth four times a day for chronic pain . Waiting for pharmacy to deliver. Review of Resident #1's progress notes, dated 07/16/24 at 10:09 AM and documented by the ADON, reflected the following: (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This nurse was notified by [Resident #1] that her oxycodone-acetaminophen was out of stock. This nurse asked CMA who informed that they did not in-fact have her routine oxycodone-acetaminophen. This nurse called NP to inform medication was out and triplicate needed to be sent. NP informed this nurse that triplicate was sent day prior. This nurse called pharmacy. Pharmacy stated triplicate not showing on their end. Re-called NP to make aware. This nurse informed script would be re-sent . Medication placed on hold until received. During a telephone interview on 07/19/24 at 11:26 AM, LVN E stated LVN D informed him at shift-change on 07/16/24 that Resident #1 was out of her oxycodone but she had re-ordered it and would come in by that night. He stated he waited but it never came. He stated he did not reach out to the pharmacy or NP. He stated Resident #1 was in pain but she did sleep that night. During a telephone interview on 07/19/24 at 1:20 PM, LVN B stated she was not sure what happened with Resident #1's oxycodone (at the beginning of July) but it was not reordered on time. She stated she was informed that another nurse had reordered it. She stated she believed it arrived on her shift and the resident was administered the medication. She stated when a resident is running low on any medication it should be reordered at least a week in advance. During a telephone interview on 07/19/24 at 2:12 PM, LVN C stated she could not remember what happened with Resident #1's medication on 07/14/24. She stated Resident #1 had run out of her pain medications a few times on different occasions. She stated during the week, staff do not order medications and it was often not there for the weekend shift. She stated Resident #1 was in continuous pain and could not miss a dose. She stated she did not reach out to the NP or the pharmacy. During a telephone interview on 07/19/24 at 2:00 PM, LVN D stated she did receive information regarding Resident #1's pain medication in the 24-hour report but she was shadowing a nurse and she was not her patient. She stated she remembered Resident #1 was asking for her pain mediation and other nurses were saying they were trying to reorder but there was an issue. She stated she did not reach out to the NP or pharmacy. Resident #2 Review of Resident #2's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, muscle wasting and atrophy, and pain. Review of Resident #2's quarterly MDS assessment, dated 07/03/24, reflected a BIMS of 4, indicating a severe cognitive impairment. Section J (Health Conditions) reflected she received a scheduled and PRN pain medication regimen and was frequently in pain. Review of Resident #2's quarterly care plan, dated 05/08/24, reflected she had chronic pain and was on pain management related to chronic physical disability with an intervention of monitoring/reporting to nurse complaints of pain or requests for pain treatment. Review of Resident #2's physician order, dated 06/01/24, reflected Fentanyl Transdermal Patch - 72-hour 37. 5 MCG/HR - apply 1 patch trans dermally every 72 hours for chronic pain and remove per schedule. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's MAR, July 2024, reflected she went without a fentanyl patch from 07/07/24 - 07/10/24 and on 07/16/24 due to none being available. Review of Resident #2's documented pain scale from 07/07/24 - 07/10/24 and on 07/16/24 reflected her highest rating was an 8. Review of Resident #2's progress notes, dated 07/07/24 at 1:09 PM and documented by RN F, reflected the following: This nurse reports that the time of completing the patch change, he notices that there is no stock to make the change, he proceeds to call the pharmacy . Review of Resident #2's progress notes, dated 07/07/24 at 4:55 PM and documented by RN F, reflected the following: Fentanyl Transdermal Patch 72-hour 37.5 MCG/HR - Apply 1 patch trans dermally every 72 hours for chronic and pain and remove per schedule. This nurse cannot comply with this indication today due to the lack of medication . During a telephone interview on 07/19/24 at 11:30 AM, RN F stated when he went to change Resident #2's fentanyl patch on 07/07/24, there were not any available patches in the cart. He stated he notified the DON and stated to move the order until the next morning and wait for the pharmacy to deliver it. He stated the resident was complaining of pain and he did administer a PRN Tramadol. He stated he did not contact the NP at this time. During an interview on 07/19/24 at 12:04 PM, Resident #1 and #2's NP stated sometimes she was given ample time for medication refill requests from staff and sometimes she was not. She stated sometimes she was made aware of residents going without medications after the fact. She stated she was not aware Resident #1 or #2 went a long period of time without pain medication. She stated if she had known, it would have been handled sooner. She stated the ADON asked her to put Resident #2's fentanyl patch on hold until a new one was delivered and was not sure why it was not put on her until 07/10/24. She stated the nurse could have easily put in a new order to restart the patch. She stated she was in the facility on 07/16/24 when Resident #1 sought her out, was very tearful, and was in moderate/severe pain. She stated she had not been notified by staff that she had been out of her pain medication for several days. She stated Resident#1 had chronic pain and should not miss any doses. She stated she was not always notified in a timely manner and would prefer to be notified of refill requests at least three days in advance. During an interview on 07/19/24 at 1:42 PM, the DON stated it was not her expectations for residents to go multiple days without their pain medications. She stated she expected nurses to re-order medications when there were seven days remaining. She stated it was all of the clinical staff's responsibility this was getting done. She stated a negative outcome of not reordering pain medications in a timely manner was increased pain, could lead to falls, or withdrawals. Review of the facility's Controlled Medications Policy, revised 12/2023, reflected the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2024
NAME OF PROVIDER OR SUPPLIER Park Manor Bee Cave		STREET ADDRESS, CITY, STATE, ZIP CODE 14058 Bee Caves Parkway, Bldg B Bee Cave, TX 78738	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Schedule II controlled medications are reordered when a seven-day supply remains to allow time for transmittal of the required original written prescription to the provider pharmacy. The ADM was notified on 07/19/24 at 3:00 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 07/20/24 at 6:52 PM: F755: Pharmacy Services: The notification of Immediate Jeopardy states as follows: On 7/19/2024, The facility must 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. The facility failed to implement a process for reordering medications in a timely manner. 1. Medical Director was notified of the IJ on 7/19/2024 at 4:55pm. The Pharmacist was notified of the IJ on 7/19/2024 at 4:58pm. 2. Resident #1 and #2 medications audited on 7/19/2024 by a sister facility DON. 3. 100% audit that all ordered pain medications are in house, and facility has minimum seven-day supply and any needed re-orders are completed by sister facility DON. 4. In-servicing began on 7/19/2024 for Licensed Nurses and CMA's to include reordering of medications and what to do if a medication is not available and will be completed by 7/20/2024 by DON or designee. All nurses and CMA's will receive in-service training. Any Nurse or CMA who has not received the in-service will not be allowed to work until in-service has been completed. Any agency, PRN or new CMA or licensed nurse will be in-serviced prior to their shift. In-service completed by DON/Designee. The DON was in-serviced and quizzed by regional consultant on 7/19/24 via phone. If medication is not available CMA's are to notify the charge nurse and licensed nurses are to notify the MD or NP immediately. The staffing schedule will be assessed daily prior to each shift by the ED/DON or designee to ensure compliance. 5. DON or Designee will monitor MAR/TAR and pain medications stored on carts weekly to ensure pain medication availability. This will practice will be ongoing. 6. DON/ADON or Designee will review order listing report daily to ensure medication availability. This process will be ongoing. 7. DON/ADON or Designee will review pain medication every Wednesday and order any that have a supply of 7 days or less. This process will be ongoing. 8. Train the Trainer in-servicing was given to the ED, DON, and RN/ED Cluster Partners by the regional consultant. 9. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks beginning 7/19/2024 or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2024
NAME OF PROVIDER OR SUPPLIER Park Manor Bee Cave		STREET ADDRESS, CITY, STATE, ZIP CODE 14058 Bee Caves Parkway, Bldg B Bee Cave, TX 78738	
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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Surveyor monitored the POR on 07/21/24 as followed: Observations made on 07/21/24 from 11:30 AM - 11:52 PM revealed three residents' scheduled narcotics matched with the narcotic count sheet on the medication carts. One of the medications was down to four days' worth left and had already been reordered. Resident #2's fentanyl patches (quantity of four) had been delivered on 07/19/24. Observation of the patch on Resident #2's right shoulder revealed the patch with the date of 07/20/24 (which coincides with her MAR). During interviews on 07/21/24 from 11:42 AM - 2:25 PM, one RN, three LVNs, and three MAs from different shifts all stated they had been in-serviced on reordering medications and pain management before working the floor. All stated that any medication needed to be reordered when there was only seven days left of medication. They then stated they would then follow-up with the pharmacy to get an ETA, and if not delivered during their shift, they would notify the NP and DON. They all stated if another staff member informed them they reached out to the pharmacy for a refill, they would not just take their word but would call the pharmacy to verify themselves. Each staff member stated if a resident was in pain, they would administered pain medication immediately. They described several signs and symptoms of non-verbal pain such as facial grimacing, moaning, and agitation. Each staff member stated it was unacceptable for a resident to go without a prescribed medication, especially if they were in pain. Review of the facility's QAPI agenda, dated 07/19/24, reflected the MD, DON, ADM, LNFAML, DON, and RNCL were in attendance. Review of an in-service entitled Process for Reordering Pain Medications and Signs and Symptoms of Pain in Residents, dated 07/19/24 and conducted by the LNFAML, reflected the ADM and DON were reeducated on the process. Review of a Medication Audit of Narcotics, dated 07/20/24, reflected pain medications on all medication carts were audited and accounted for. Review of an in-service entitled Process for Reordering Pain Medications and Signs and Symptoms of Pain in Residents, from 07/20/24 - 07/21/24, reflected all medication aides and nurses were educated on the process. While the IJ was removed on 07/21/24 at 12:50 PM, the facility remained at a level of actual no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.		