STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 - 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** 50042 Based on observations, interviews 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 1 of 6 residents (Resident #1), reviewed for pharmaceutical services, in that: The facility failed to ensure that Resident #1 was administered Morphine 10mg ER in accordance with the physician's order when the resident was administered Morphine 100mg instead. This failure placed the resident at risk for adverse reactions that could have been life threatening, and which lead to the hospitalization of Resident #1 for acute respiratory distress. The findings included: An interview with the resident was attempted via telephone on November 1, 2024. The attempt was unsuccessful as the resident did not answer or respond to the call. Record review of Resident #1's admission record revealed the resident was an [AGE] year old female who was admitted to the facility on [DATE], with diagnoses that included: unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified lack of coordination, muscle weakness, difficulty walking, cognitive communication deficit, major depressive disorder, recurrent, moderate, generalized anxiety disorder, fibromyalgia (a medical syndrome that causes chronic widespread pain), acute kidney failure, chronic kidney disease, and systematic lupus erythematosus (superficial reddening of the skin), organ or system involvement unspecified. Record review of Resident #1's care plan, (with an initiation date of 05/21/2024) revealed in part: Resident #1 was on pain medication therapy and had an intervention to administer medication as ordered, monitor for altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus (itchy skin), respiratory distress, sedation, and urinary retention. Observe for adverse reactions with every interaction with the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 - Actual harm Residents Affected - Few	Resident #1 had acute/chronic pain related to fibromyalgia and lupus and had an intervention to anticipate the need for pain relief and respond immediately to any complaint of pain and follow the pain scale to medicate as ordered. In an interview with Resident #1's RR on November 1, 2024, at 11:23AM, RR stated that she was contacted by the facility on October 30, 2024, at 5:13PM, but missed their call. At 5:15PM on October 30, 2024, as RR was about to return the facility's call, RR's phone rang. The person on the other end was the DON for the facility. RR stated that she had never spoken to the DON before. The DON informed RR that the doctor had changed Resident #1's pain medication to Morphine yesterday (October 29, 2024) and that Morphine had been administered that day (October 30, 2024). However, there had been a mistake with the dose administered and Resident #1 was administered Morphine 100mg instead of Morphine 10mg. According to RR, the DON was unsure what the Morphine was being administered for, but further explained this was a pharmacy error although a facility CMA had administered the dose. The RR said that the DON told the RR that they had Narcan on-hand if Resident #1 experienced respiratory distress or shallow breathing, but further added that the Narcan would be of no benefit at that time as it should have been administered immediately if it was going to be administered. The DON informed RR that the resident was fine all day. The DON told RR that the resident did experience sleepiness and sweating, but this was probably because the resident insisted that the window in her room be opened. The DON told RR that they had been checking the resident's vitals signs every 30 minutes-1 hours. The RR insisted that the resident be taken to the ED. The DON agreed. The RR called Resident #1 to check on the resident and Resident #1 had not been told of the mistake with her medication. Resident #1 told RR that her head was hurting, she had not been feeling right, but she could not get any help. RR then called the DON back to make sure they were transporting the resident to the ED and the DON said she was filling out the transfer/ED paperwork. RR said the DON again blamed the pharmacy for the mistake. RR called Resident #1 once again and EMS had arrived to take the resident to the ED. RR said Resident #1 was admitted to the hospital where she remained at the time of this interview. RR stated that Resident #1 was an emotional wreck and had trouble recognizing RR for over 15 minutes, which was not normal for the resident. RR said Resident #1 has not been the same since. In an interview with MD, on November 1, 2024, at 12:03PM, MD confirmed he was employed with the facility and took over Resident #1's care in September 2024. At the time MD assumed Resident #1's care, she had been taking Tramadol 4 times a day for 1 year. Resident #1 complained to MD of constant pain and stated that the Tramadol was no longer working. As a result, MD switched Resident #1 to Oxycontin 10mg 2 times a day as this medication was long-acting. This medication worked for the resident, but the resident's insurance refused to cover the medication. MD said he was then forced to switch the resident to MS Contin or Morphine. A review of MD's records on November 1, 2024, of Resident #1's prescription for Morphine, revealed that MD wrote the prescription on October 28, 2024, which stated, START Morphine ER 10mg PO Q 12hrs scheduled #60 (sixty) tabs. MD said the first and only dose administered to Resident #1 was the overdose of Morphine 100mg. MD stated that he learned of the mistake when the pharmacy contacted him on October 30, 2024, to confirm his order. MD said the adverse effect of an overdose of this type would be respiratory sedation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 - Actual harm Residents Affected - Few	In an interview with the DON on November 1, 2024, at 12:14PM, the DON stated that she was contacted by the RPh in the morning of October 30, 2024, and informed that an order entry error had been made by the pharmacy when filling Resident #1's Morphine prescription. RPh stated that instead of filling the prescription as ordered (Morphine ER 10mg), the pharmacy mistakenly filled the prescription for Morphine 100mg. The RPh asked the DON if the medication had been administered. The DON stated that she would check and let the RPh know. The DON reviewed Resident #1's medical record and found that Morphine 100mg had been administered to Resident #1 at 9:30AM by the CMA. The DON stated that she pulled the medication from the cart and notified LVN #1 of the error and the need to monitor Resident #1's vital signs every 30 minutes. The DON stated that she notified the RPh, who created and sent the facility a plan of correction. The RPh confirmed the facility had Narcan on hand. The DON then called the MD and the facility's Medical Director. The DON stated that she attempted contact with RR 3 times that day and left RR a general message to return her call. The DON stated Resident #1 did not experience any respiratory distress or any need for the use of Narcan. The DON stated that Resident #1 did not display signs or symptoms that would warrant that she be immediately sent to the ED. But the DON stated that staff did send Resident #1 to the ED upon RR's request. At the time of her transfer to the ED, Resident #1 was alert and oriented x3 per the DON. The DON stated that this had been the first time this medication was ordered for Resident #1. Resident #1 had been taking Tramadol then Oxycodone for pain, both of which had been discontinued. In an interview with the Administrator (ADM) on November 1, 2024, at 12:20PM, the ADM stated that RR had been contacted, although they have no formal POA on file for RR. The ADM stated that the RR had made an issue in the past of not being contacted so they had been doing so as a courtesy and while RR provided the enacted POA for Resident #1. The ADM stated that upon learning of the incident, the facility and staff took actions to remedy the mistake including in-service education. The CMA who administered the medication was suspended as a part of their disciplinary action process. The ADM stated that the CMA is a good employee, who has not committed a policy infraction of this sort in the past. The ADM confirmed that the CMA had no complaints or issues of this type prior to her employment at this facility to her knowledge. Review of the facility's personnel records for CMA on November 1, 2024, at 1:49PM revealed CMA had been employed at the facility since approximately the end of May 2024, passed background checks, had an active CMA certificate/registration, was not listed in the EMR, and had no prior disciplinary actions at this facility. Record review of the facility's communication with the pharmacy on October 30, 2024, at 4:25PM, revealed the following record of events per RPh: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 - Actual harm Residents Affected - Few	On 10/29/24 at 12:11pm we received a new prescription from MD for morphine 10mg ER tablets to be given to [Resident #1] every 12 hours routinely. The order was typed by pharmacy technician VS and was erroneously entered into the system as morphine 100mg ER rather than the 10mg ER that was prescribed . [RPh #2] reviewed the data entry and did not catch the closing error. He approved the order for filling and the medication was filled. [RPh #2] also reviewed the filled medication and did not catch the dosing error at that time. The order was delivered to the facility last night as a partial fill of twenty-five tablets out of a total of 60 that were ordered. This morning we received more of the morphine 100mg ER tablets in stock to complete filling the order. It was filled for the remainder owed and [RPh#3] reviewed the filled product-at that stage, the data entry error was caught and it was realized that the wrong strength had been sent last night. I was notified of the situation within minutes and immediately called you to inform you of the error so that steps could be taken to reduce any risk of harm to the patient . In an interview with CMA on November 1, 2024, at 1:57PM, CMA stated that she saw Resident #1's medication had been changed to Morphine. CMA said she looked at the MAR and it said Morphine 10mg. CMA said she picked up the medication in preparation for administration and failed to see the medication was Morphine 100mg, not Morphine 10mg. CMA said she administered the medication around 9AM and at around 12PM the DON came and asked her if she had administered the medication. CMA told the DON she had administered the medication. The CMA and the DON confirmed that the medication was for the wrong dosage. CMA said she never observed Resident #1 suffering from any adverse effects from the medication. CMA stated that she observed Resident #1 several times after giving the medication, but before learning of her mistake, and noticed nothing out of the ordinary with regards to Resident #1's presentation or behavior. After learning of her mistake, observation and assessments of Resident #1 were done. CMA stated that Resident #1 never exhibited any reactions that would indicate life threatening effects of the medication, including respiratory distress or shallow breathing, CMA took full responsibility for her mistake and expressed remorse. CMA stated that she has never made a mistake like this before. Record review of Resident #1's medical record progress notes revealed the following: 10/29/2024 22:19 (10:19PM)-Type: Nursing Note Text: New order received during 6a-6p shift to d/c oxycodone and start morphine sulfate Extended Release 24 hour 10mg, will continue with plan of care. 10/30/2024 15:52 (3:52PM)-Type Nursing Note Text: Received call .pharmacy technician entered new order for morphine 10mg wrong in their system. Resident received the incorrect dose of 100mg tab. Upon receiving this information, resident was assessed . no respiratory distress was noted obtained the following reading: 148/70 (blood pressure), 78 (pulse/beats per minute) 18, 97.3 (temperature), 94% room air (oxygen saturation rate) .MDs made aware. Directions given to monitor resident every 30 mins for the first hour, and then every hour and to have Narcan on hand to administer if resident experiences respiratory distress .Medication pack retrieved from medication cart to be returned to pharmacy .Resident had her therapy session and had her meals, no changes on LOC noted, resident stayed up throughout the day, denied discomfort or having difficulty breathing. No restlessness, N/V, loss of coordination, dizziness, hallucinations, and s/sx of confusion noted. Resident had therapy session, ate lunch, and was her normal self without any deviation from her daily activities or routine . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 - Actual harm Residents Affected - Few	Record review of Resident #1's Nurses Notes on 10/30/2024 revealed a notation stating that the resident was monitored as directed by MD every 30 minutes, then hourly. No respiratory distress noted. Vital signs remained stable. The documentation shows checks and vitals signs were taken at 12:15PM, 12:45PM, 1:15PM, 1:45PM, 2:15PM, 3:15PM, 4:15PM, and 5:15PM. Record review on November 1, 2024, at 3:31PM revealed a Medication Error Report completed on 10/30/2024, regarding Resident #1 receiving the wrong dose of Morphine. Measures taken to prevent recurrence of similar errors listed were in serviced nurses and medication aides, did one-on-one in service with CMA. Record review of Resident #1's hospital records dated October 30, 2024, revealed Resident #1 was hospitalized in the ICU from 10/30/2024 to 11/06/2024 with a diagnoses of Accidental overdose, narcotic overdose, accidental or unintentional. Resident #1 required hospitalization in the ICU due to the overdose of morphine. It was noted patient is post [sic] to be on morphine tablets 10 mg twice daily but instead received 100 mg due to a pharmacy there at the nursing home . She is somnolent (lethargic, sleepy) and when she falls asleep her oxygen saturation dips into the mid 80's. Patient was started on 4 L via nasal cannula which brought her O2 saturation up to 99%. Resident #1 was noted to be in acute distress when she arrived at the EDR and with mild hypoxemia (abnormally low level of oxygen in the blood) at 87% on room air. In addition, Resident #1 was inattentive, with slurred speech, slowed behavior with an elated mood. Resident #1 was not noted to have received Narcan at the nursing facility. The hospital documentation also noted that Resident #1's RR was the one who called 911 for Resident #1 to be sent to the hospital and not the facility. Observation of medication administration on December 3, 2024, at 8:36 AM for Resident #7 revealed the following medications administered with no concerns: Nasal flutacsone 1 spray each nostril gloves Artificial tears 1 drop each eye hand hygiene 1 gabapentin cap 100mg 1 po tid 1 entresto tab 24-26mg 1 tab po bid hold as directed-hold hr < bp <100 1 diltiazem tab 60mg 1 po bid hold if 1 metformin 500mg 1 po bid 1 Bumetanide tab 0.5mg 1 po daily 1 Metoprol suc tab 50 mg ER 1 po daily HOLD as dire 1 K chloride 20 meq ER 1 daily 1 multivitamin] 1 iron tab (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 - Actual harm Residents Affected - Few	1 Metamucil 1 packet resident drinks slowly There were 12 Opportunities to include 9 tabs administered plus three other medications. CMA practiced hand hygiene and exited the room. In an in interview with DON on December 12, 2024, at approximately 2:15 PM, it was stated that Resident #1 was not administered Narcan as the resident did not display any signs or symptoms of respiratory distress. It was stated by the DON that those signs and symptoms would have been apparent within 4 hours of the administration of the medication. Those signs and symptoms would have been respiratory distress, sweating, hyperventilation, and disorientation. It was stated by DON that the resident was told several times about the accidental overdose. DON stated during each check of Resident #1 following the discovery of the overdose, the resident was reminded of the reason for the frequent checks and assessments. DON stated that Resident #1 responded with Okay. DON stated that Resident #1 never reported not feeling right or having a headache to staff after receiving the Morphine 100mg. DON reported that Resident #1 exhibited no atypical behaviors in that Resident #1 participated in a full therapy session, ate lunch in the dining room, and had focused conversations with staff and others. DON stated that if Resident #1 had exhibited a significant change in her condition, the resident would have been sent out to the ED immediately. DON stated that CMAs can administer routine narcotics if a nurse signs off on the administration. DON stated PRN medications are given by nurses. DON stated that the administration of an initial dose of narcotics by a CMA is allowed with the oversight of a nurse. In an interview with the ADM on December 12, 2024, at approximately 2:30pm, it was stated that the facility has implemented no policy and procedure changes regarding medication administration, receipt of narcotics, or transfer/discharging of residents (sending residents out to the ED). Observation of medication administration on December 12, 2024, at 3:41 PM, for Resident #5 and #6 revealed the following medications administered by CMA #2 with no concerns: MEMANTINE TAB HCL 5MG ORAL (1) MED PASS 2.0 FORTIFIED NUTRITIONAL SHAKE 90ML ORAL ELIQUIS TAB 2.5MG ORAL (1) DIVALPROEX TAB 125MG DR (1) ORAL ELIQUIS TAB 2.5 MG (1) ORAL MEMANTINE TAB HCL 10MG (1) ORAL (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 - Actual harm Residents Affected - Few	In an interview with CMA #2 on December 12, 2024, at approximately 3:41 PM, CMA #2 stated that if she encounters a medication during administration that she is not familiar with, she will ask a nurse to administer the medication or get education or clarification on the medication. CMA #2 stated that only routine medications are administered by CMAs. PRN medications are administered by nurses and the initial dose of a routine narcotic is typically administered by a nurse. CMA #2 stated that upon administering any medication, she checks the resident's MAR, checks the medication label, and if she has questions about the medication, she will ask a nurse before administering the medication. CMA #2 stated that if she noticed any kind of adverse reaction or out of the ordinary response to a medication administered, she would notify the nurse immediately. In an interview with MDS Coordinator on December 12, 2024, at 6:42 PM, it was stated that the MDS Coordinator's office is right behind the nurses station on the south side of the building. On the day of the incident, the MDS Coordinator observed Resident #1 after lunch at the nurses' desk talking to the nurses and the aids. Resident #1 was standing and talking as usual and did not appear to be in any type of distress. The MDS Coordinator also observed Resident #1 walking and had no concerns for the resident. MDS Coordinator stated that she was surprised to hear the next day that the resident had been sent out to the ED. In an interview with SC on December 12, 2024, at 6:45 PM, it was stated that SC observed Resident #1 early the day of the incident and the resident's behavior was typical and not out of the ordinary. The resident was observed walking, talking and interacting as normal, with no concerns noted. In an interview with COTA on December 12, 2024, at 6:49 PM, it was stated that COTA did an entire session with Resident #1 and the resident was her normal self. Friendly, talkative, no complaints of pain, or complaints otherwise. In an interview with MD #2 on December 16, 2024, at 3:30 PM, MD #2 stated that Resident #1 was sent out to the ED as a safety precaution based on RR request, but not because MD #2 felt the resident was unsafe or compromised . MD #2 said looking at the situation from the outside, a dose that high would appear concerning. But he was very familiar with the resident and her history and background. MD #2 said Resident #1 could tolerate a dose that high and it didn't really phase her. He said she suffered no adverse reaction. MD #2 said Resident #1 had hypoxemia at baseline. He believes the resident was coded with acute respiratory distress upon her admission to the hospital for billing purposes. MD #2 said from his experience that it's likely the hospital's standard protocol is to admit to the ICU rather than the floor for monitoring purposes only. He also thinks Resident #1's stay in the hospital was prolonged because the RR was attempting to find a different placement following Resident #1's discharge from the hospital, which probably took several days. MD #2 said he wished the resident hadn't been moved because he had cared for her for some time and knew her and her conditions well. MD #2 said the facility staff responded to the situation as directed and he has no concerns for the way the situation was handled. It was just an unfortunate mistake. Review of the facility's personnel records for CMA revealed CMA had been employed at the facility since approximately the end of May 2024, passed background checks, had an active CMA certificate/registration, was not listed in the EMR, and had no prior disciplinary actions at this facility. Record review of the facility's policy and procedure dated July 2017, regarding Administration of Medications revealed the following in part: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 - Actual harm Residents Affected - Few	3. Medications must be administered in accordance with the written orders of the attending physician; 11. Prior to administering the resident's medication, the nurse or medication technician should compare the drug and dosage schedule [don] the resident's MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse or med tech should check the physician's orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50042 Based on observations, interviews and record review, the facility failed to ensure residents were free of any significant medication errors for 1 (Resident #1) of 6 residents reviewed for medication administration. Resident #1 was administered Morphine 100mg ER instead of Morphine 10mg ER as ordered, which was outside of physician parameters. This failure could place residents at risk for not receiving the intended therapeutic benefit of their prescribed medication, worsening or exacerbating chronic medical conditions, placing residents at risk for adverse reactions that could be life threatening, and hospitalization . The findings included: An interview with the resident was attempted via telephone on November 1, 2024. The attempt was unsuccessful as the resident did not answer or respond to the call. Record review of Resident #1's admission record revealed the resident was an [AGE] year old female who was admitted to the facility on [DATE], with diagnoses that included: unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified lack of coordination, muscle weakness, difficulty walking, cognitive communication deficit, major depressive disorder, recurrent, moderate, generalized anxiety disorder, fibromyalgia (a medical syndrome that causes chronic widespread pain), acute kidney failure, chronic kidney disease, and systematic lupus erythematosus (superficial reddening of the skin), organ or system involvement unspecified. Record review of Resident #1's care plan, (with an initiation date of 05/21/2024) revealed in part: Resident #1 was on pain medication therapy and had an intervention to administer medication as ordered, monitor for altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus (itchy skin), respiratory distress, sedation, and urinary retention. Observe for adverse reactions with every interaction with the resident. Resident #1 had acute/chronic pain related to fibromyalgia and lupus and had an intervention to anticipate the need for pain relief and respond immediately to any complaint of pain and follow the pain scale to medicate as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview with Resident #1's RR on November 1, 2024, at 11:23AM, RR stated that she was contacted by the facility on October 30, 2024, at 5:13PM, but missed their call. At 5:15PM on October 30, 2024, as RR was about to return the facility's call, RR's phone rang. The person on the other end was the DON for the facility. RR stated that she had never spoken to the DON before. The DON informed RR that the doctor had changed Resident #1's pain medication to Morphine yesterday (October 29, 2024) and that Morphine had been administered that day (October 30, 2024). However, there had been a mistake with the dose administered and Resident #1 was administered Morphine 100mg instead of Morphine 10mg. According to RR, the DON was unsure what the Morphine was being administered for, but further explained this was a pharmacy error although a facility CMA had administered the dose. The RR said that the DON told the RR that they had Narcan on-hand if Resident #1 experienced respiratory distress or shallow breathing, but further added that the Narcan would be of no benefit at that time as it should have been administered immediately if it was going to be administered. The DON informed RR that the resident was fine all day. The DON told RR that the resident did experience sleepiness and sweating, but this was probably because the resident insisted that the window in her room be opened. The DON told RR that they had been checking the resident's vitals signs every 30 minutes-1 hours. The RR insisted that the resident be taken to the ED. The DON agreed. The RR called Resident #1 to check on the resident and Resident #1 had not been told of the mistake with her medication. Resident #1 told RR that her head was hurting, she had not been feeling right, but she could not get any help. RR then called the DON back to make sure they were transporting the resident to the ED and the DON said she was filling out the transfer/ED paperwork. RR said the DON again blamed the pharmacy for the mistake. RR called Resident #1 once again and EMS had arrived to take the resident to the ED. RR said Resident #1 was admitted to the hospital where she remained at the time of this interview. RR stated that Resident #1 was an emotional wreck and had trouble recognizing RR for over 15 minutes, which was not normal for the resident. RR said Resident #1 has not been the same since. In an interview with MD, on November 1, 2024, at 12:03PM, MD confirmed he was employed with the facility and took over Resident #1's care in September 2024. At the time MD assumed Resident #1's care, she had been taking Tramadol 4 times a day for 1 year. Resident #1 complained to MD of constant pain and stated that the Tramadol was no longer working. As a result, MD switched Resident #1 to Oxycontin 10mg 2 times a day as this medication was long-acting. This medication worked for the resident, but the resident's insurance refused to cover the medication. MD said he was then forced to switch the resident to MS Contin or Morphine. A review of MD's records on November 1, 2024, of Resident #1's prescription for Morphine, revealed that MD wrote the prescription on October 28, 2024, which stated, START Morphine ER 10mg PO Q 12hrs scheduled #60 (sixty) tabs. MD said the first and only dose administered to Resident #1 was the overdose of Morphine 100mg. MD stated that he learned of the mistake when the pharmacy contacted him on October 30, 2024, to confirm his order. MD said the adverse effect of an overdose of this type would be respiratory sedation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview with the DON on November 1, 2024, at 12:14PM, the DON stated that she was contacted by the RPh in the morning of October 30, 2024, and informed that an order entry error had been made by the pharmacy when filling Resident #1's Morphine prescription. RPh stated that instead of filling the prescription as ordered (Morphine ER 10mg), the pharmacy mistakenly filled the prescription for Morphine 100mg. The RPh asked the DON if the medication had been administered. The DON stated that she would check and let the RPh know. The DON reviewed Resident #1's medical record and found that Morphine 100mg had been administered to Resident #1 at 9:30AM by the CMA. The DON stated that she pulled the medication from the cart and notified LVN #1 of the error and the need to monitor Resident #1's vital signs every 30 minutes. The DON stated that she notified the RPh, who created and sent the facility a plan of correction. The RPh confirmed the facility had Narcan on hand. The DON then called the MD and the facility's Medical Director. The DON stated that she attempted contact with RR 3 times that day and left RR a general message to return her call. The DON stated Resident #1 did not experience any respiratory distress or any need for the use of Narcan. The DON stated that Resident #1 did not display signs or symptoms that would warrant that she be immediately sent to the ED. But the DON stated that staff did send Resident #1 to the ED upon RR's request. At the time of her transfer to the ED, Resident #1 was alert and oriented x3 per the DON. The DON stated that this had been the first time this medication was ordered for Resident #1. Resident #1 had been taking Tramadol then Oxycodone for pain, both of which had been discontinued. In an interview with the Administrator (ADM) on November 1, 2024, at 12:20PM, the ADM stated that RR had been contacted, although they have no formal POA on file for RR. The ADM stated that the RR had made an issue in the past of not being contacted so they had been doing so as a courtesy and while RR provided the enacted POA for Resident #1. The ADM stated that upon learning of the incident, the facility and staff took actions to remedy the mistake including in-service education. The CMA who administered the medication was suspended as a part of their disciplinary action process. The ADM stated that the CMA is a good employee, who has not committed a policy infraction of this sort in the past. The ADM confirmed that the CMA had no complaints or issues of this type prior to her employment at this facility to her knowledge. Review of the facility's personnel records for CMA on November 1, 2024, at 1:49PM revealed CMA had been employed at the facility since approximately the end of May 2024, passed background checks, had an active CMA certificate/registration, was not listed in the EMR, and had no prior disciplinary actions at this facility. Record review of the facility's communication with the pharmacy on October 30, 2024, at 4:25PM, revealed the following record of events per RPh: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 0760 Level of Harm - Actual harm Residents Affected - Few	On 10/29/24 at 12:11pm we received a new prescription from MD for morphine 10mg ER tablets to be given to [Resident #1] every 12 hours routinely. The order was typed by pharmacy technician VS and was erroneously entered into the system as morphine 100mg ER rather than the 10mg ER that was prescribed . [RPh #2] reviewed the data entry and did not catch the closing error. He approved the order for filling and the medication was filled. [RPh #2] also reviewed the filled medication and did not catch the dosing error at that time. The order was delivered to the facility last night as a partial fill of twenty-five tablets out of a total of 60 that were ordered. This morning we received more of the morphine 100mg ER tablets in stock to complete filling the order. It was filled for the remainder owed and [RPh#3] reviewed the filled product-at that stage, the data entry error was caught and it was realized that the wrong strength had been sent last night. I was notified of the situation within minutes and immediately called you to inform you of the error so that steps could be taken to reduce any risk of harm to the patient . In an interview with CMA on November 1, 2024, at 1:57PM, CMA stated that she saw Resident #1's medication had been changed to Morphine. CMA said she looked at the MAR and it said Morphine 10mg. CMA said she picked up the medication in preparation for administration and failed to see the medication was Morphine 100mg, not Morphine 10mg. CMA said she administered the medication around 9AM and at around 12PM the DON came and asked her if she had administered the medication. CMA told the DON she had administered the medication. The CMA and the DON confirmed that the medication was for the wrong dosage. CMA said she never observed Resident #1 suffering from any adverse effects from the medication. CMA stated that she observed Resident #1 several times after giving the medication, but before learning of her mistake, and noticed nothing out of the ordinary with regards to Resident #1's presentation or behavior. After learning of her mistake, observation and assessments of Resident #1 were done. CMA stated that Resident #1 never exhibited any reactions that would indicate life threatening effects of the medication, including respiratory distress or shallow breathing, CMA took full responsibility for her mistake and expressed remorse. CMA stated that she has never made a mistake like this before. Record review of Resident #1's medical record progress notes revealed the following: 10/29/2024 22:19 (10:19PM)-Type: Nursing Note Text: New order received during 6a-6p shift to d/c oxycodone and start morphine sulfate Extended Release 24 hour 10mg, will continue with plan of care. 10/30/2024 15:52 (3:52PM)-Type Nursing Note Text: Received call .pharmacy technician entered new order for morphine 10mg wrong in their system. Resident received the incorrect dose of 100mg tab. Upon receiving this information, resident was assessed . no respiratory distress was noted obtained the following reading: 148/70 (blood pressure), 78 (pulse/beats per minute) 18, 97.3 (temperature), 94% room air (oxygen saturation rate) .MDs made aware. Directions given to monitor resident every 30 mins for the first hour, and then every hour and to have Narcan on hand to administer if resident experiences respiratory distress .Medication pack retrieved from medication cart to be returned to pharmacy .Resident had her therapy session and had her meals, no changes on LOC noted, resident stayed up throughout the day, denied discomfort or having difficulty breathing. No restlessness, N/V, loss of coordination, dizziness, hallucinations, and s/sx of confusion noted. Resident had therapy session, ate lunch, and was her normal self without any deviation from her daily activities or routine . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 0760 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's Nurses Notes on 10/30/2024 revealed a notation stating that the resident was monitored as directed by MD every 30 minutes, then hourly. No respiratory distress noted. Vital signs remained stable. The documentation shows checks and vitals signs were taken at 12:15PM, 12:45PM, 1:15PM, 1:45PM, 2:15PM, 3:15PM, 4:15PM, and 5:15PM. Record review on November 1, 2024, at 3:31PM revealed a Medication Error Report completed on 10/30/2024, regarding Resident #1 receiving the wrong dose of Morphine. Measures taken to prevent recurrence of similar errors listed were in serviced nurses and medication aides, did one-on-one in service with CMA. Record review of Resident #1's hospital records dated October 30, 2024, revealed Resident #1 was hospitalized in the ICU from 10/30/2024 to 11/06/2024 with a diagnoses of Accidental overdose, narcotic overdose, accidental or unintentional. Resident #1 required hospitalization in the ICU due to the overdose of morphine. It was noted patient is post [sic] to be on morphine tablets 10 mg twice daily but instead received 100 mg due to a pharmacy there at the nursing home . She is somnolent (lethargic, sleepy) and when she falls asleep her oxygen saturation dips into the mid 80's. Patient was started on 4 L via nasal cannula which brought her O2 saturation up to 99%. Resident #1 was noted to be in acute distress when she arrived at the EDR and with mild hypoxemia (abnormally low level of oxygen in the blood) at 87% on room air. In addition, Resident #1 was inattentive, with slurred speech, slowed behavior with an elated mood. Resident #1 was not noted to have received Narcan at the nursing facility. The hospital documentation also noted that Resident #1's RR was the one who called 911 for Resident #1 to be sent to the hospital and not the facility. Observation of medication administration on December 3, 2024, at 8:36 AM for Resident #7 revealed the following medications administered with no concerns: Nasal flutacsone 1 spray each nostril gloves Artificial tears 1 drop each eye hand hygiene 1 gabapentin cap 100mg 1 po tid 1 entresto tab 24-26mg 1 tab po bid hold as directed-hold hr < bp <100 1 diltiazem tab 60mg 1 po bid hold if 1 metformin 500mg 1 po bid 1 Bumetanide tab 0.5mg 1 po daily 1 Metoprol suc tab 50 mg ER 1 po daily HOLD as dire 1 K chloride 20 meq ER 1 daily 1 multivitamin] 1 iron tab (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 0760 Level of Harm - Actual harm Residents Affected - Few	1 Metamucil 1 packet resident drinks slowly There were 12 Opportunities to include 9 tabs administered plus three other medications. CMA practiced hand hygiene and exited the room. In an in interview with DON on December 12, 2024, at approximately 2:15 PM, it was stated that Resident #1 was not administered Narcan as the resident did not display any signs or symptoms of respiratory distress. It was stated by the DON that those signs and symptoms would have been apparent within 4 hours of the administration of the medication. Those signs and symptoms would have been respiratory distress, sweating, hyperventilation, and disorientation. It was stated by DON that the resident was told several times about the accidental overdose. DON stated during each check of Resident #1 following the discovery of the overdose, the resident was reminded of the reason for the frequent checks and assessments. DON stated that Resident #1 responded with Okay. DON stated that Resident #1 never reported not feeling right or having a headache to staff after receiving the Morphine 100mg. DON reported that Resident #1 exhibited no atypical behaviors in that Resident #1 participated in a full therapy session, ate lunch in the dining room, and had focused conversations with staff and others. DON stated that if Resident #1 had exhibited a significant change in her condition, the resident would have been sent out to the ED immediately. DON stated that CMAs can administer routine narcotics if a nurse signs off on the administration. DON stated PRN medications are given by nurses. DON stated that the administration of an initial dose of narcotics by a CMA is allowed with the oversight of a nurse. In an interview with the ADM on December 12, 2024, at approximately 2:30pm, it was stated that the facility has implemented no policy and procedure changes regarding medication administration, receipt of narcotics, or transfer/discharging of residents (sending residents out to the ED). Observation of medication administration on December 12, 2024, at 3:41 PM, for Resident #5 and #6 revealed the following medications administered by CMA #2 with no concerns: MEMANTINE TAB HCL 5MG ORAL (1) MED PASS 2.0 FORTIFIED NUTRITIONAL SHAKE 90ML ORAL ELIQUIS TAB 2.5MG ORAL (1) DIVALPROEX TAB 125MG DR (1) ORAL ELIQUIS TAB 2.5 MG (1) ORAL MEMANTINE TAB HCL 10MG (1) ORAL (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview with CMA #2 on December 12, 2024, at approximately 3:41 PM, CMA #2 stated that if she encounters a medication during administration that she is not familiar with, she will ask a nurse to administer the medication or get education or clarification on the medication. CMA #2 stated that only routine medications are administered by CMAs. PRN medications are administered by nurses and the initial dose of a routine narcotic is typically administered by a nurse. CMA #2 stated that upon administering any medication, she checks the resident's MAR, checks the medication label, and if she has questions about the medication, she will ask a nurse before administering the medication. CMA #2 stated that if she noticed any kind of adverse reaction or out of the ordinary response to a medication administered, she would notify the nurse immediately. In an interview with MDS Coordinator on December 12, 2024, at 6:42 PM, it was stated that the MDS Coordinator's office is right behind the nurses station on the south side of the building. On the day of the incident, the MDS Coordinator observed Resident #1 after lunch at the nurses' desk talking to the nurses and the aids. Resident #1 was standing and talking as usual and did not appear to be in any type of distress. The MDS Coordinator also observed Resident #1 walking and had no concerns for the resident. MDS Coordinator stated that she was surprised to hear the next day that the resident had been sent out to the ED. In an interview with SC on December 12, 2024, at 6:45 PM, it was stated that SC observed Resident #1 early the day of the incident and the resident's behavior was typical and not out of the ordinary. The resident was observed walking, talking and interacting as normal, with no concerns noted. In an interview with COTA on December 12, 2024, at 6:49 PM, it was stated that COTA did an entire session with Resident #1 and the resident was her normal self. Friendly, talkative, no complaints of pain, or complaints otherwise. In an interview with MD #2 on December 16, 2024, at 3:30 PM, MD #2 stated that Resident #1 was sent out to the ED as a safety precaution based on RR request, but not because MD #2 felt the resident was unsafe or compromised . MD #2 said looking at the situation from the outside, a dose that high would appear concerning. But he was very familiar with the resident and her history and background. MD #2 said Resident #1 could tolerate a dose that high and it didn't really phase her. He said she suffered no adverse reaction. MD #2 said Resident #1 had hypoxemia at baseline. He believes the resident was coded with acute respiratory distress upon her admission to the hospital for billing purposes. MD #2 said from his experience that it's likely the hospital's standard protocol is to admit to the ICU rather than the floor for monitoring purposes only. He also thinks Resident #1's stay in the hospital was prolonged because the RR was attempting to find a different placement following Resident #1's discharge from the hospital, which probably took several days. MD #2 said he wished the resident hadn't been moved because he had cared for her for some time and knew her and her conditions well. MD #2 said the facility staff responded to the situation as directed and he has no concerns for the way the situation was handled. It was just an unfortunate mistake. Review of the facility's personnel records for CMA revealed CMA had been employed at the facility since approximately the end of May 2024, passed background checks, had an active CMA certificate/registration, was not listed in the EMR, and had no prior disciplinary actions at this facility. Record review of the facility's policy and procedure dated July 2017, regarding Administration of Medications revealed the following in part: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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 0760 Level of Harm - Actual harm Residents Affected - Few	3. Medications must be administered in accordance with the written orders of the attending physician; 11. Prior to administering the resident's medication, the nurse or medication technician should compare the drug and dosage schedule [don] the resident's MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse or med tech should check the physician's orders.