STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676380	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Center for Skilled Care	3701 Wasson Rd Big Spring, TX 79720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04033 Based on interview and record review, the facility failed to immediately notify the resident's physician and representative(s) when there was a significant change in the resident's physical status for one (Resident #1) of four residents reviewed for changes in condition, in that: The facility failed to immediately notify the Physician (MD A) and Responsible Party (RP A) of a medication error that involved Resident #1 receiving resident#2's medication. This error cause Resident #1's blood pressure to decrease, to be administered and IV, and to be sent to the hospital. This failure placed residents at risk of not having physician (MD) and Responsible Party (RP) input and involvement in their care and treatment decisions. Findings included: Record review of Resident #1's Order Summary Report with active orders as of [DATE] indicated she was admitted to the facility on [DATE] with diagnoses of other specified Hypothyroidism (thyroid gland doesn't produce enough thyroid hormone that can disrupt heart rate, body temperature and all aspects of metabolism), need for assistance with personal care, Alzheimer's disease with late onset (progressive decline in episodic memory, with variable involvement of other cognitive domains), Epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizure), Hyperlipidemia, (high levels of fat particles (lipids) in the blood), Hypertension (force of the blood against the artery walls is too high), and Dementia (group of thinking and social symptoms that interferes with daily functioning). This report included the following orders for the 6 P.M. medication administration: Donepezil HCl tablet 10 mg, give 1 tablet by mouth one time a day related to Alzheimer's disease with late onset; Olanzapine oral tablet 15 mg, given by mouth at bedtime related to psychotic delusions due to known psychological condition; Pravastatin Sodium tablet 40 mg, give one tablet by mouth one time a day related to mixed hyperlipidemia; Gabapentin oral capsule 100 mg, give 1 capsule 100 mg by mouth two times a day for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet): Keppra tablet 500 mg, give one tablet by mouth two times a day related to Epilepsy, Acetaminophen tablet 325 mg, give 2 tablets by mouth three times a day for pain, and Buspirone HCl oral tablet 10 mg, give 1.5 tablet by mouth three times a day related to dementia. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Medication Administration Record for [DATE] - [DATE] indicated on [DATE], she was scheduled to receive at 7:00 P.M. the following medications: Donepezil HCL tablet 10 milligrams (mg) one time a day related to Alzheimer's disease with late onset, and documented with a 6 by RN A. This MAR indicated the code 6 was for hospitalized ; Olanzapine oral tablet 15 mg, give 15 mg by mouth at bedtime related to psychotic disorder with delusions due to known psychological condition and documented with a 6 by RN A; Pravastatin Sodium Tablet 40 mg, give 1 tablet by mouth one time a day related to mixed hyperlipidemia documented with a 6 by RN A; Gabapentin oral capsule 100 mg, give 1 capsule by mouth two times a day for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), was documented with a 6 by RN A; Keppra Tablet 500 mg, give 1 tablet by mouth two times a day related to other Epilepsy, was documented with a 6 by RN A; Acetaminophen tablet 325 mg give 1 tablet by mouth three times a day for pain, give two tablets of 325 mg tablets=650 mg, Buspirone HCl oral tablet 10 mg, give 1.5 tablets by mouth three times a day related to unspecified dementia with agitation, was documented with a 6 by RN A. Record review of Resident #2's Order Summary Report with active order as of [DATE] indicated he was admitted to the facility [DATE] with diagnoses of need for assistance with personal care, cognitive communications deficit, hypertension (force of the blood against the artery walls is too high), Alzheimer's disease (a progressive disease that destroys memory and other important functions), and Hyperlipidemia (high levels of fat particles (lipids) in the blood). This report included the following orders for the 6 P.M. medication administration: Atorvastatin Calcium Oral Tablet 40 mg, give 1 tablet by mouth one time a day related to Hyperlipidemia; Levothyroxine Sodium oral tablet 88 MCG related to Hypothyroidism; and Spironolactone oral tablet, give 1 tablet by mouth two times a day for edema/fluid retention. Review of Resident #2's Medication Administration Record for [DATE] - [DATE] indicated he was supposed to be administered Atorvastatin Calcium Oral Tablet 40 mg, give 1 tablet by mouth one time a day related to Hyperlipidemia; Levothyroxine Sodium oral tablet 88 MCG (one millionth of one gram) related to Hypothyroidism; and Spironolactone oral tablet, give 1 tablet by mouth two times a day for edema/fluid retention. Record review of facility's Medication Error dated [DATE] at 6:34 P.M. indicated on [DATE] at 6:30 P.M. the error was wrong medication administered. The description of this error was There was a medication error by incorrect resident that occurred and transferred to ER. The error was caused by a medication precupping (putting medications into a cup prior to medication pass) and administering to the wrong resident. Error was discovered when Certified Medication Aide A and she reported error to LVN A. CMA A stated she identified the medication error within 5 to 10 minutes of administering medications, stopped medication pass, and notified LVN A. LVN A assessed Resident #1, who had a blood pressure (BP) of 67 over 47, which was too low (average blood pressure of ,d+[DATE] is defined as a systolic pressure of less than 120 and a diastolic pressure of less than 80). Record review of Resident #1's Nursing Progress Note written by LVN A on [DATE] at 4:56 P.M., indicated on [DATE] at 9:42 P.M. Upon assessment writer noticed Resident #1s blood pressure (BP) was below normal. No signs of distress noted. Attempted to increase BP with initiating IV fluids while awaiting DON response via phone for further instructions. 24 gauge to left wrist, started 500 ml of 0.9% sodium chloride at 250 ml/hr. No increase in BP after several minutes. Sent to hospital's ER via ambulance per DON. And Physician and responsible party were notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's SBAR dated [DATE] at 6:30 P.M. indicated her functional status changed because she was hypotensive (low blood pressure, which can cause fainting or dizziness because the brain doesn't receive enough blood), her blood pressure was ,d+[DATE], pulse was 50, respirations were 20, temperature 97.1 and saturation was 96 at room air. Resident #1 was administered with 24 gauge to left wrist 500 ml of 0.9% sodium chloride at 250 mL/hr (volume divided by total time in hours) with no improvement. This included order from MD to send to the ER. Record review of Resident #1's Emergency Department Document dated [DATE] indicated EMS received call from facility that Resident #1 received Spironolactone and her blood pressure was running low. EMS noted Resident 1's pulse rate was 50, oxygen saturation was 94, and blood pressure was ,d+[DATE]. This report indicated complaint for Resident #1 was for hypotensive, and she was transferred to the ER. During an interview on [DATE] at 11:42 A.M. Family Member (FM A) indicated on [DATE] at approximately 9 P.M., LVN A called her to inform her that Resident #1 was sent to the hospital because her blood pressure was low and if she tested ok, she would return to the facility. RP A said LVN A did not inform her that Resident #1 was administered medications that belonged to another resident at approximately 6:30 pm. RP A said the hospital's nurse (unknown name) informed her that facility's staff said they had administered Resident #1 too much Spironolactone (diuretic). FMA asked how much, and the nurse replied 25 mg. That was when RP A informed the hospital nurse that Resident #1 does not take Spironolactone. On [DATE], RP A said she called the facility and spoke to the Administrator and informed him the hospital nurse informed her the facility's staff gave Resident #1 too much Spironolactone, which caused her blood pressure to decrease. The Administrator informed her that CMA A administered Resident #2's medication to Resident #1. RP A said she was upset because the facility on [DATE] did not inform her of Resident' #1s medication error or that they had to start an IV on her before she was sent to the hospital. RP A said facility's staff know they are supposed to call her, especially with giving Resident #1 another resident's medication, that caused her to be administered an IV at the facility. FMA said Resident #1 is ill, frail, confused and could have died . During an interview on [DATE] at 4:24 P.M. with LVN B said she was working on [DATE] when LVN A informed her CMA A administered Resident #2's medications to Resident #1. LVN B said LVN A reported that Resident #1's blood pressure had dropped because she was administered Spironolactone and wanted to know the fastest way to increase her blood pressure. LVN B directed her to notify the physician. Shortly afterwards, LVN B said she saw LVN A with all the supplies for administering an IV. During an interview on [DATE] at 8:01 A.M. CNA A indicated she was working on [DATE] when at approximately 6:30 P.M. she overheard a CMA A say Resident #2's medication was administered to Resident #1. Afterwards, CNA A said she saw LVN A continuously entering Resident #1's room, and LVN A placed an IV on her arm. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:24 A.M. LVN A indicated she was working on [DATE], when at approximately 6:37 P.M. CMA A said she administered Resident #2's medications to Resident #1. LVN A said CMA A got confused with the medications because the cups, which had been set up before she started her shift, had Resident #2's first name and Resident #1's last name, which are almost the same. LVN A said she monitored Resident #1's blood pressure, which remained between ,d+[DATE] and 15 minutes later at , d+[DATE] (average blood pressure of ,d+[DATE] is defined as a systolic pressure of less than 120 and a diastolic pressure of less than 80). LVN A said she did not call the MD A immediately because Resident #1 did not have any signs or symptoms of distress but did call him later. MD A directed her to send Resident #1 to the hospital's emergency room (ER). LVN A said at 9:50 P.M. she sent Resident #1 to the ER, then notified RP Aat 9:52 P.M. LVN A said CMA A, who normally works as the CNA, was asked to fill in as the CMA, because the CMA scheduled to work had to leave early. LVN said she recalled seeing two cups labeled with Resident #'s last name and Resident #1's last name, which are almost the same. During an interview on [DATE] at 9:17 A.M. CMA A indicated she was asked to fill in as the CMA on [DATE], because the CMA on duty could not work late. CMA A said she went to the facility and directly into the medication room, where she was met by LVN C, who gave her report and directed her to pass the medications. CMA A said she started her medication pass and saw that all the medications were in cups labeled with resident's names in the medication cart. CMA A said in the middle of administering medications, the DON directed her to go to hall 200; even though she told her she was administering medications. CMA A said in hall 200, which was the secured unit, she filled in as the CNA and CMA. Afterwards she returned to the main dining area where she continued administering medications from two medication carts that had cups with medications and labeled with residents' names. CMA A said she administered Resident #1 her medications, but when she walked away, she realized the cup was labeled with Resident #2's first name, which closely matches Resident #1's last name. CMA A said she immediately informed LVN A of this error. During an interview on ,d+[DATE] 24 at 10:42 A.M. with LVN D indicated she was working on [DATE], when she pulled medications for CMA A to store in her carts. LVN D said she did not see medications cup with pills in the medication cart. During an interview on [DATE] at 12:24 P.M. MD A indicated the nurse should have notified him immediately after she was notified of the medication error that involved Resident #1 being administered Resident #2's medication. During an interview on [DATE] at 12:26 P.M. with DON indicated on [DATE] CMA B was assigned to work from 6 A.M. to 4 P.M. and CMA C was assigned to work from 6 P.M. to 7 P.M.; however; she could not work. DON contacted CMA A who agreed to work as the CMA from 4 P.M. to 7 P.M. DON said she was not aware the medications were placed into cups and labeled with the residents' names. After the medications error involving Resident #1 being administered Resident #2's medications on [DATE] at approximately 6:30 P.M. and CMA A took full responsibility for this error. DON said LVN A left her a message at 6:50 P.M. informing her about the medication error and did not make it sound urgent and to call her at her earliest convenience. DON said later, LVN A informed her that MD A had given an order to administer IV to Resident #1 because her blood pressure was ,d+[DATE] (normal range ,d+[DATE]) for more than an hour. That was when DON called LVN A and directed her to suspend CMA A. DON said LVN A should have called MD A immediately and family prior to calling her. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:04 AM, CMA B indicated she worked on [DATE] from approximately 6 A. M. to 2 P.M., when she was informed by DON that CMA A would take over her shift because she had to leave early. CMA B said she asked DON if she could help CMA A with the medications, because she had never administered medications to the residents at the facility, and she was not familiar with the medication carts and process. The DON replied she could help her out, and that was why she set up cups with medications and labeled them with resident's names. CMA B said she recalled labeling a cup with Resident #2's first name and Resident #1's last name, which are very similar. Afterwards, CMA B said she left the facility at 2 P.M. and CMA A started her shift at 4 P.M. Record review of the facility's policy and procedure dated 2003 indicated Medication errors and adverse drug reactions are immediately reported to the resident's Physician. In addition, the Director of Nurses and/or designee should be notified of any medication's errors. The policy and procedure for Medication Incident Report Procedure dated 2003 indicated The attending physician and family member will be promptly notified of any medication administration incident. The policy and procedure for Resident Rights dated [DATE] indicated the resident had the right for Notification of changes, A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04033 Based on interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #3) reviewed for accidents and hazards. NA A used a sliding board to transfer Resident #3 on a sliding board she had not been trained to use. This deficient practice could place residents transferred via sliding board at risk of falls which could result in injury and hospitalization . Findings include: Record review of Resident #3's Admission Record indicated he was admitted to the facility on [DATE]. This report included his diagnoses as pressure ulcer of right heel (caused by factors such as pressure shear and friction) and acquired absence of left leg below the knee. Record review of Resident #3's Admission Minimum Data Set (MDS) assessment dated [DATE] indicated he scored a 14 on his Brief Interview for Mental Status, which indicated he was cognitively intact. This MDS's Functional Abilities and Goals indicated he used a wheelchair; and the area for transfers and toileting were left blank. Record review of Resident #3's Fall-Risk assessment dated [DATE] indicated he was admitted to the facility on [DATE] with diagnoses of pressure ulcer of right heel and acquired absence of left leg below the knee and had scored a 6 (medium risk). And his predisposing conditions included hypotension (can cause fainting or dizziness because the brain doesn't receive enough blood), vertigo (a sensation of motion or spinning that is often described as dizziness), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), loss of limb, seizures (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain, arthritis (swelling and tenderness in one or more joints, causing joint pain or stiffness that often gets worse with age), osteoporosis, and fractures (the cracking or breaking of a bone). This report indicate Resident #3 could not stand. Record review of Resident #3's Initial Skin assessment dated [DATE] indicated he had no bruises, skin tears, abrasion, lacerations, surgical incision, rash, and other skin findings (unstageable to right heel, no treatment orders at this time). Record review of Resident #3's Event Nurses' Note - Fall dated 05/09/24 and signed by RN B, reflected he had an assisted fall, and he was oriented. The nursing description of the event indicated he had active range of motion to bilateral lower extremities, tender upon touch to left side, physician was notified of finding and received order for portable x-ray to left hip and left femur and continue to monitor per facility's policy and procedures. Resident #3 rated his pain on a scale of 1 to 10 at a 3. This report indicted Resident #3 said the girl was putting me on the toilet with the board, it moved, she held me, and I hurt my hip area. The physician was notified on 05/09/24 at 1 pm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Skilled Nurses Notes dated 05/08/24 indicated Resident #3 indicated he had no pain in the last 5 days, and for transfers, he needs help with sit to stand, chair/bed to chair transfer, and toilet transfer. Record review of Resident #1's Radiology Report dated 05/09/24 at 4:15 P.M. the x-rays to the left femur indicated he had no definite evidence of acute fracture or dislocation, he had mild osteoporosis (bones are weak and brittle), and mild osteoarthritis (arthritis that occurs when flexible tissue at the ends of bone wears down). Record review of Resident #1's Nursing Progress Report dated 05/10/24 at 4:09 P.M. Indicated his pelvis pain, was due to osteopenia (body does not make new bone as quickly as it reabsorbs old bone, and degenerative disease (function or structure of the affected tissue or organs changes for the worse over time, no acute pathology). Review of MDS dated [DATE] indicated Resident #3 discharged from the facility on 05/10/24 (approximatley 7:43 per family member). During a telephone interview on 05/13/24 at 12:56 P.M., Family Member (FM A) assisted Resident #3 with this interview, and he said he needed to go to the bathroom. That was when Nurse Aide (NA A) directed him to place his arms around her neck as she transferred him from the bed to the wheelchair as he sat and slid across the sliding board. Resident #3 said NA A used the same method to transfer him from his wheelchair to the toilet, but the board slipped, and he landed on the stump causing it to open. Resident #3 said NA A struggled to put him back on the toilet but between them, he was able to slide back onto the board to his wheelchair. Resident #3 said he was at the facility for therapy but due to this injury he asked his family to take him home, because he feared being dropped again. On 05/10/24, Resident #3 said he informed FM A that he was dropped while being transferred and his hip was hurting. FM A said she discharged him from the facilty on 05/10/24 at approximatley 7:43 pm. During an interview on 05/13/24 at 3:07 P.M, with Director of Rehabilitation (DOR) indicated Resident #3's PT evaluation dated 05/09/24 included he reported having fallen during the night while being transferred. On 05/09/24, DOR said he overheard Resident #3 report to Physical Therapist Assistant (PTA A) that he was dropped but she did not see a fall report. DOR said she asked Resident #1 if he was in pain and he said yes on his left leg and hip, and he showed her the scab on his stump that had opened. DOR said Resident #3 should not have been transferred by staff via a sliding board, because there must be an in-service and demonstration on the use of this board by the rehabilitation department. During an interview on 05/13/24 at 3:56 P.M. with PTA A indicated he was teaching Resident #3 on the use of the sliding board, when Resident #1 said he fell off the sliding board and hit the floor, when an NA (tried to transfer him on the sliding board that was in his room.) PTA A said Resident #3 complained of hip pain and pain on his stump, and a gash on his stump, as witnessed by PTA A. During an interview on 05/13/24 at 4:24 P.M. with LVN B indicated she worked caring for Resident #3 from 6 P.M. on 05/08/24 to 6 A.M. on 05/09/24 and the Nurse Aide caring for him was NA A. LVN B said it was not reported to her that Resident #1 had a fall during the night, and if he had one, the NA was responsible for reporting this to her charge nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/13/24 at 7:25 P.M. RN A indicated she was not aware Resident #3 had fallen during the night and did not receive that during her shift report on 05/09/24 at 6 AM. RN A said NA A was the only assigned staff to Hall 100 from 6 P.M. on 05/08/24 to 6 A.M. on 05/09/24, and she never mentioned any issues with transferring Resident #3. During an interview on 05/13/24 at 8:20 A.M. with Nurse Aide (NA A) indicated she was working hall 100, when Resident #3 requested to go to the toilet. NA A said she assisted Resident #3 from his bed to his wheelchair by sliding on his sliding board. In the bathroom, NA A said she transferred Resident #3 from his wheelchair to the toilet using the sliding board. NA A said she was standing behind Resident #3 when his buttocks slipped off. That was when she placed her arms under his arm pits and after struggling, she managed to put him back on the board. NA A said Resident #3 went down a bit, but she squatted and used her leg strength to keep him from falling. Afterwards, NA A said she put him on his wheelchair as he scooted on the sliding board, then transferred him back on his bed in the same manner using the sliding board. NA A said at the start of her shift she didn't receive a shift report, and this was the first time she met Resident #3 was when she transferred him. NA A said she didn't know he had a missing leg. NA A said she did not ask for a second person to assist her with Resident #3's transfer because he told her what to do. NA A said she had not been in-serviced on how to use a sliding board, and this was the first time she had used one to transfer a resident. NA A said she did not report this incident because Resident #3 did not fall to the floor, instead she stopped him from falling on the floor. During an interview on 05/14/24 at 12:26 pm with DON indicated an unintentional change in plane is considered a fall, which includes a resident being assisted to the floor by staff. DON said she was informed on 05/09/24 that Resident #3 sustained a fall while NA A was using a sliding board. DON said NA A was using a sliding board that she had not been trained to use. DON said she did not even know Resident #3 was using a sliding board. Record review of policies and procedures for Preventive Strategies to Reduce Fall Risk dated 10/05/2016 indicated The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintain or improving the resident's mobility. Procedures: After risk is assessed, individualized nursing care plan will be implemented to prevent fall. The resident and family members will be educated on methods to prevent falls. Interventions will focus on manipulating the environment, educating the resident/family, implementing rehabilitation programs to improve functional ability, and care monitoring of medication side effects. Incident Reporting: Reported falls will be thoroughly investigated to assess fall risk factors and contributing factors in order to provide a safe environment for the residents. Education: the importance of calling for assistance during periods of increased risk, and what to do if a fall occurs etc. Record review of Job Description for Student Nurse Aide dated 2010 indicated Ambulate and transfer residents, utilizing appropriate assistive devices and body mechanics. And this position reports directly to the Charge Nurse.

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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** 04033 Based on interview, and record review, the facility failed to ensure 1 of 4 residents (Resident #1) reviewed for medication administration were free of significant medication errors. CMA A on [DATE] administered Resident #2's medications to Resident #1, which caused her blood pressure (BP) to decrease, and she was sent to the hospital. This failure could place residents at risk for receiving medications that were ordered for a different resident and could have possible adverse reactions. Findings included: Record review of Resident #1's Order Summary Report with active orders as of [DATE] indicated she was admitted to the facility on [DATE] with diagnoses of other specified Hypothyroidism (thyroid gland doesn't produce enough thyroid hormone that can disrupt heart rate, body temperature and all aspects of metabolism), need for assistance with personal care, Alzheimer's disease with late onset (progressive decline in episodic memory, with variable involvement of other cognitive domains), Epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizure), Hyperlipidemia, (high levels of fat particles (lipids) in the blood), Hypertension (force of the blood against the artery walls is too high), and Dementia (group of thinking and social symptoms that interferes with daily functioning). This report included the following orders for the 6 P.M. medication administration: Donepezil HCl tablet 10 mg, give 1 tablet by mouth one time a day related to Alzheimer's disease with late onset; Olanzapine oral tablet 15 mg, given by mouth at bedtime related to psychotic delusions due to known psychological condition; Pravastatin Sodium tablet 40 mg, give one tablet by mouth one time a day related to mixed hyperlipidemia; Gabapentin oral capsule 100 mg, give 1 capsule 100 mg by mouth two times a day for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet): Keppra tablet 500 mg, give one tablet by mouth two times a day related to Epilepsy, Acetaminophen tablet 325 mg, give 2 tablets by mouth three times a day for pain, and Buspirone HCl oral tablet 10 mg, give 1.5 tablet by mouth three times a day related to dementia. Record review of Resident #1's Medication Administration Record for [DATE] - [DATE] indicated on [DATE], she was scheduled to receive at 7:00 P.M. the following medications: Donepezil HCL tablet 10 milligrams (mg) one time a day related to Alzheimer's disease with late onset, and documented with a 6 by RN A. This MAR indicated the code 6 was for hospitalized ; Olanzapine oral tablet 15 mg, give 15 mg by mouth at bedtime related to psychotic disorder with delusions due to known psychological condition and documented with a 6 by RN A; Pravastatin Sodium Tablet 40 mg, give 1 tablet by mouth one time a day related to mixed hyperlipidemia documented with a 6 by RN A; Gabapentin oral capsule 100 mg, give 1 capsule by mouth two times a day for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), was documented with a 6 by RN A; Keppra Tablet 500 mg, give 1 tablet by mouth two times a day related to other Epilepsy, was documented with a 6 by RN A; Acetaminophen tablet 325 mg give 1 tablet by mouth three times a day for pain, give two tablets of 325 mg tablets=650 mg, Buspirone HCl oral tablet 10 mg, give 1.5 tablets by mouth three times a day related to unspecified dementia with agitation, was documented with a 6 by RN A. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676380	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Center for Skilled Care	3701 Wasson Rd Big Spring, TX 79720

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(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 #2's Order Summary Report with active order as of [DATE] indicated he was admitted to the facility [DATE] with diagnoses of need for assistance with personal care, cognitive communications deficit, hypertension (force of the blood against the artery walls is too high), Alzheimer's disease (a progressive disease that destroys memory and other important functions), and Hyperlipidemia (high levels of fat particles (lipids) in the blood). This report included the following orders for the 6 P.M. medication administration: Atorvastatin Calcium Oral Tablet 40 mg, give 1 tablet by mouth one time a day related to Hyperlipidemia; Levothyroxine Sodium oral tablet 88 MCG related to Hypothyroidism; and Spironolactone oral tablet, give 1 tablet by mouth two times a day for edema/fluid retention. Review of Resident #2's Medication Administration Record for [DATE] - [DATE] indicated he was supposed to be administered Atorvastatin Calcium Oral Tablet 40 mg, give 1 tablet by mouth one time a day related to Hyperlipidemia; Levothyroxine Sodium oral tablet 88 MCG (one millionth of one gram) related to Hypothyroidism; and Spironolactone oral tablet, give 1 tablet by mouth two times a day for edema/fluid retention. Record review of facility's Medication Error dated [DATE] at 6:34 P.M. indicated on [DATE] at 6:30 P.M. the error was wrong medication administered. The description of this error was There was a medication error by incorrect resident that occurred and transferred to ER. The error was caused by a medication precupping (putting medications into a cup prior to medication pass) and administering to the wrong resident. Error was discovered when Certified Medication Aide A and she reported error to LVN A. CMA A stated she identified the medication error within 5 to 10 minutes of administering medications, stopped medication pass, and notified LVN A. LVN A assessed Resident #1, who had a blood pressure (BP) of 67 over 47, which was too low (average blood pressure of ,d+[DATE] is defined as a systolic pressure of less than 120 and a diastolic pressure of less than 80). Record review of Resident #1's Nursing Progress Note written by LVN A on [DATE] at 4:56 P.M., indicated on [DATE] at 9:42 P.M. Upon assessment writer noticed Resident #1s blood pressure (BP) was below normal. No signs of distress noted. Attempted to increase BP with initiating IV fluids while awaiting DON response via phone for further instructions. 24 gauge to left wrist, started 500 ml of 0.9% sodium chloride at 250 ml/hr. No increase in BP after several minutes. Sent to hospital's ER via ambulance per DON. And Physician and responsible party were notified. Record review of Resident #1's SBAR dated [DATE] at 6:30 P.M. indicated her functional status changed because she was hypotensive (low blood pressure, which can cause fainting or dizziness because the brain doesn't receive enough blood), her blood pressure was ,d+[DATE], pulse was 50, respirations were 20, temperature 97.1 and saturation was 96 at room air. Resident #1 was administered with 24 gauge to left wrist 500 ml of 0.9% sodium chloride at 250 mL/hr (volume divided by total time in hours) with no improvement. This included order from MD to send to the ER. Record review of Resident #1's Emergency Department Document dated [DATE] indicated EMS received call from facility that Resident #1 received Spironolactone and her blood pressure was running low. EMS noted Resident 1's pulse rate was 50, oxygen saturation was 94, and blood pressure was ,d+[DATE]. This report indicated complaint for Resident #1 was for hypotensive, and she was transferred to the ER. (continued on next page)

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	676380	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Center for Skilled Care	3701 Wasson Rd Big Spring, TX 79720

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(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	During an interview on [DATE] at 11:42 A.M. Family Member (FM A) indicated on [DATE] at approximately 9 P.M., LVN A called her to inform her that Resident #1 was sent to the hospital because her blood pressure was low and if she tested ok, she would return to the facility. RP A said LVN A did not inform her that Resident #1 was administered medications that belonged to another resident at approximately 6:30 pm. RP A said the hospital's nurse (unknown name) informed her that facility's staff said they had administered Resident #1 too much Spironolactone (diuretic). FMA asked how much, and the nurse replied 25 mg. That was when RP A informed the hospital nurse that Resident #1 does not take Spironolactone. On [DATE], RP A said she called the facility and spoke to the Administrator and informed him the hospital nurse informed her the facility's staff gave Resident #1 too much Spironolactone, which caused her blood pressure to decrease. The Administrator informed her that CMA A administered Resident #2's medication to Resident #1. RP A said she was upset because the facility on [DATE] did not inform her of Resident' #1s medication error or that they had to start an IV on her before she was sent to the hospital. RP A said facility's staff know they are supposed to call her, especially with giving Resident #1 another resident's medication, that caused her to be administered an IV at the facility. FMA said Resident #1 is ill, frail, confused and could have died . During an interview on [DATE] at 4:24 P.M. with LVN B said she was working on [DATE] when LVN A informed her CMA A administered Resident #2's medications to Resident #1. LVN B said LVN A reported that Resident #1's blood pressure had dropped because she was administered Spironolactone and wanted to know the fastest way to increase her blood pressure. LVN B directed her to notify the physician. Shortly afterwards, LVN B said she saw LVN A with all the supplies for administering an IV. During an interview on [DATE] at 8:01 A.M. CNA A indicated she was working on [DATE] when at approximately 6:30 P.M. she overheard a CMA A say Resident #2's medication was administered to Resident #1. Afterwards, CNA A said she saw LVN A continuously entering Resident #1's room, and LVN A placed an IV on her arm. During an interview on [DATE] at 8:24 A.M. LVN A indicated she was working on [DATE], when at approximately 6:37 P.M. CMA A said she administered Resident #2's medications to Resident #1. LVN A said CMA A got confused with the medications because the cups, which had been set up before she started her shift, had Resident #2's first name and Resident #1's last name, which are almost the same. LVN A said she monitored Resident #1's blood pressure, which remained between ,d+[DATE] and 15 minutes later at , d+[DATE] (average blood pressure of ,d+[DATE] is defined as a systolic pressure of less than 120 and a diastolic pressure of less than 80). LVN A said she did not call the MD A immediately because Resident #1 did not have any signs or symptoms of distress but did call him later. MD A directed her to send Resident #1 to the hospital's emergency room (ER). LVN A said at 9:50 P.M. she sent Resident #1 to the ER, then notified RP Aat 9:52 P.M. LVN A said CMA A, who normally works as the CNA, was asked to fill in as the CMA, because the CMA scheduled to work had to leave early. LVN said she recalled seeing two cups labeled with Resident #'s last name and Resident #1's last name, which are almost the same. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 9:17 A.M. CMA A indicated she was asked to fill in as the CMA on [DATE], because the CMA on duty could not work late. CMA A said she went to the facility and directly into the medication room, where she was met by LVN C, who gave her report and directed her to pass the medications. CMA A said she started her medication pass and saw that all the medications were in cups labeled with resident's names in the medication cart. CMA A said in the middle of administering medications, the DON directed her to go to hall 200; even though she told her she was administering medications. CMA A said in hall 200, which was the secured unit, she filled in as the CNA and CMA. Afterwards she returned to the main dining area where she continued administering medications from two medication carts that had cups with medications and labeled with residents' names. CMA A said she administered Resident #1 her medications, but when she walked away, she realized the cup was labeled with Resident #2's first name, which closely matches Resident #1's last name. CMA A said she immediately informed LVN A of this error. During an interview on ,d+[DATE] 24 at 10:42 A.M. with LVN D indicated she was working on [DATE], when she pulled medications for CMA A to store in her carts. LVN D said she did not see medications cup with pills in the medication cart. During an interview on [DATE] at 12:26 P.M. with DON indicated on [DATE] CMA B was assigned to work from 6 A.M. to 4 P.M. and CMA C was assigned to work from 6 P.M. to 7 P.M.; however; she could not work. DON contacted CMA Awho agreed to work as the CMA from 4 P.M. to 7 P.M. DON said she was not aware the medications were placed into cups and labeled with the residents' names. After the medications error involving Resident #1 being administered Resident #2's medications on [DATE] at approximately 6:30 P.M. and CMA A took full responsibility for this error. DON said LVN A left her a message at 6:50 P.M. informing her about the medication error and did not make it sound urgent and to call her at her earliest convenience. DON said later, LVN A informed her that MD A had given an order to administer IV to Resident #1 because her blood pressure was ,d+[DATE] (normal range ,d+[DATE]) for more than an hour. That was when DON called LVN A and directed her to suspend CMA A. During an interview on [DATE] at 11:04 AM, CMA B indicated she worked on [DATE] from approximately 6 A.M. to 2 P.M., when she was informed by DON that CMA A would take over her shift because she had to leave early. CMA B said she asked DON if she could help CMA A with the medications, because she had never administered medications to the residents at the facility, and she was not familiar with the medication carts and process. The DON replied she could help her out, and that was why she set up cups with medications and labeled them with resident's names. CMA B said she recalled labeling a cup with Resident #2's first name and Resident #1's last name, which are very similar. Afterwards, CMA B said she left the facility at 2 P.M. and CMA A started her shift at 4 P.M. Record review of the facility's policy and procedure dated 2003 for Medication Administration Procedures indicated Open the unit dose package only when you are administering medication directly to the resident. Removing the medication from its unit dose packaging in advance lessens the ability to positively identify the medication and increase the chances of drug administration errors and contamination. Before administering the dose, the nurse must make certain to correctly identify the resident to whom the medication is being administered. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record. It is recommended that medications be charted immediately after administration, but if facility policy permits, medications may be charted immediately before administration. Initials are to be used. Check marks are not acceptable.