STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676466	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne Medical Lodge	750 Highway 352 Mesquite, TX 75149

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 - Minimal harm or potential for 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** 27070 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for one (Residents #4,) of three residents reviewed for pharmacy services. 1. The facility failed to administer medications as ordered, Lidocaine HCL at 5% external patch to Resident #4 on 03/18/24, 03/19/24, 03/21/24, 03/24/24,and 03/26/24. These failures placed residents at risk for not receiving the therapeutic effect of their medications as ordered by the physician. Findings included: Record Review of Resident #4's quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Parkinsonism, asthma, and chronic lower back pain. Resident #4 was moderately impaired for decision making and required one staff for assistance with activities of daily life. Record Review of Resident #4's Physician Orders reflected: 03/01/24 Lidocaine HCL at 5% external patch (pain and stiffness) apply to lower back one time a day. On in the am off in the pm as scheduled. 03/27/24 Lidocaine HCL at 4% OTC (over the counter)external patch apply to lower back one time a day. On in the am off in the pm as scheduled. Record Review of Resident #4s MARs for March 2024 reflected the Resident # 4 did not receive: Lidocaine HCL patch at 5% external patch on 03/18/24, 03/19/24, 03/21/24, 03/24/24, and 03/26/24 for the am dose. (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 03/26/24 at 11:21 a.m. with MA C revealed while administering Resident #4's medications, there were no Lidocaine patches available to apply to her back. MA C stated the Lidocaine patches had been ordered but had never come in. MA C stated she told the nurse in charge, and they order them, but she did not have any. In an interview with Resident #4 on 03/27/24 at 11:10 a.m. revealed the facility did not have any Lidocaine patches for her back yesterday and several days last week, and the week before. Resident #4 stated when she admitted to the facility, she was using the Lidocaine patches already and her doctor had told her it was alright to continue to use them. She stated this was the only month (March) that had been inconsistent, the other months had been fine, and she had received her patches without any problems. Resident #4 stated she had asked every day, but sometimes they have them and sometimes they do not, when I asked the lady that was supposed to put them on my back, she tells me the patches have been ordered but they have not come in. Resident #4 stated she had been okay without them so far, her back was stiff, but did not hurt, her back feels better when she has them, I still can do everything I usually do without any pain. In an interview on 03/27/24 at 2:00 p.m. with LVN B revealed if there was an over-the-counter medication that required re-ordering than I would tell the DON or the central supply personal. LVN B stated the Lidocaine patches are kept in the medication room on the shelf if you don't have any on the cart. If they are not there or on the cart, then I would look on the other carts to see if there are any. In an interview on 03/27/24 at 2:10 p.m. with LVN A revealed the over-the counter drugs are given by the medication aide and not the nurse. If the medication needed to be reordered the medication aide would tell me and I would reorder in the computer system. LVN A stated we have a lot of residents that are on Lidocaine patches, I am not aware of needing to reorder the lidocaine patches for anyone. In an interview on 03/27/24 at 2:20 p.m. with the DON and Administrator revealed the Lidocaine patches had been a problem. The DON stated the doctors wanted to order the Lidocaine patches 5% and our pharmacy formulary will not pay for those. The DON stated she was just made aware of this problem yesterday. The DON stated she had contacted the physician and their nurse practitioners to inform them that the Lidocaine patches 4% would be covered by the formulary on yesterday. I told the physicians that the new orders should read Lidocaine patches 4%. The DON stated she was not aware the Resident #4 had not been receiving her lidocaine patches as the physician ordered. An interview on 03/27/24 at 2:45 PM with the Medical Director revealed the physician was not aware of the facility having had an issue with getting medications from the pharmacy . The DON informed me yesterday that the Lidocaine patches that were ordered were not covered by the pharmacy and I had to order the lesser strength. (4 %) I was not informed that Resident #4 had only been receiving Lidocaine patches inconsistently this month. The facility was good about communicating with me, but I did not know about the failure to provide medication that had been ordered. Review of the Facility undated Policy and Procedure, Medications, Ordering and Receiving from Pharmacy reflected: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: 1. To ensure timely arrival of medications ordered from the pharmacy .procedure: 1. Medications orders are phoned or faxed to the pharmacy and written on a medication order form provided by the pharmacy for the purpose. The entry includes: a. dated ordered. b. Whether the order is new or a repeat order (refill), if the repeat order, include prescription number. c. patients name and room number d. medications name and strength, when indicated. e. Direction for use, if a need order or direction change to previous order g. Physician's name 2. Info ration concerning repeat medications (refills) will be written on a medication order form provided by the pharmacy for that purpose, or transferred to the form on a peel-off label, and ordered as follows: a. Order medication within 72 hours of the last dose available. B. the nurse who orders the medication is responsible for notifying the pharmacy of changes in directions for use of previous labeling errors. C. The refill order is called in, faxed, or otherwise transmitted to the pharmacy . Receiving Medications: 1. A licensed nurse receives medications, delivered to the facility and documents delivery on the medication receipt record. Theis nurse verifies medications received and directions for use with the medication order and receipt record. Discrepancies and omissions are reported promptly to the issuing pharmacy and the charge nurse supervisor. 2. Pharmacy delivers medications with that delivery receipt or check-off and documentation by the nursing staff. A report of all medications delivered is provided with the scheduled delivery. 3. There delivery records are retained for an appropriate amount of time to reconcile and reordering issues.