| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676469 | A. Building<br>B. Wing | 04/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Premier Snf of Alice | 800-A Coyote Trail<br>Alice, TX 78332 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 2 of 8 residents (Resident #16 and Resident #110) reviewed for pharmacy services in that: The facility failed to notice the narcotic sheet count for Acetaminophen-Codeine (narcotic pain medication) for Resident #110 did not match the remaining number of tablets in the blister pack through 12 administrations of the medication on various dates and times.The facility failed to notice the narcotic sheet count for Acetaminophen-Codeine for Resident #110 did not match the remaining number of tablets in the blister pack when it was set for destruction and locked in the DON's office.The facility failed to document destruction of 1 tablet of Acetaminophen-Codeine properly on 12/03/25.The facility failed to document the time of administration of 1 tablet of Acetaminophen-Codeine to Resident #110 on 01/02/26.The facility failed to administer Resident #16's Ativan (a medication used for anxiety and behavioral outburst) as ordered for the months of March 2026 and April 2026. This failure could place residents at risk for non-therapeutic responses to medications and place residents' medications vulnerable to drug diversion.Findings included:<br><br>Record review of Resident #110's face sheet dated 04/24/26 revealed an [AGE] year-old female with an admission dated of 11/26/25 and a discharge date of 02/03/26. Pertinent diagnosis included Pain, unspecified.<br><br>Record review of Resident #110's Discharge MDS assessment dated [DATE] revealed a BIMS score of 11 which indicated moderate cognitive impairment.<br><br>Record review of Resident #110's comprehensive care plan dated 04/24/26 revealed the focus The resident has a potential for uncontrolled pain. An intervention for the focus included Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.<br><br>Record review of Resident #1's order summary dated 04/24/26 revealed a discontinued order for Acetaminophen-Codeine Oral Tablet 300-30 MG as needed every 6 hours initiated on 12/03/25 and discontinued on 02/03/26.<br><br>Record review of Resident #110's narcotic sheet for Acetaminophen-Codeine Tablet 300-30 MG revealed 28 tablets were received on 12/03/25 and 16 tablets remained on 01/31/26 after the last administration of the medication. Further review revealed 12 tablets had been administered with 1 tablet administered on each of the following dates and times:<br><br>12/5/25 at 8:00 AM<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 12/10/25 at 4:45 PM<br><br>12/11/25 at 1:00 PM<br><br>12/17/25 at 2:00 PM<br><br>12/18/25 at 6:00 PM<br><br>12/24/25 at 8:00 AM<br><br>12/25/25 at 10:30 PM<br><br>12/26/25 at 10:00 AM<br><br>12/28/25 at 8:00 PM<br><br>01/02/26 with no time listed<br><br>01/27/26 at 6:38 AM<br><br>01/31/26 at 11:30 PM<br><br>During an observation of the lock box containing narcotics set for destruction in the DON's office at 4:09 PM on 04/23/26, the blister pack for Resident #110's order for Acetaminophen-Codeine 300-30 MG contained 14 tablets. Further observation showed 14 bubbles of the blister pack had been opened.<br><br>In an interview with the DON at 10:41 AM on 04/24/26, the DON stated nurses brought narcotics that were to be destroyed to her and she locked the narcotic sheet along with the blister pack together in a locked drawer in her office. The DON stated there was no way to determine when exactly the narcotic sheet and blister pack for Acetaminophen-Codeine 300/30 MG for Resident #110 was placed in the locked drawer. The DON stated she was supposed to ensure the count matched on the blister pack and narcotic sheet before placing it in the locked drawer. The DON stated she did not specifically remember counting this blister pack and narcotic sheet. The DON stated there were 14 tablets remaining in the blister pack, but the narcotic sheet revealed there should be 16 remaining in the blister pack indicating there were 2 tablets unaccounted for. The DON stated she discovered RN G and LVN H both popped a tablet out of the blister pack but did not sign the narcotic sheet on 12/03/25. The DON stated RN G popped the first one, but accidentally dropped it, so she called LVN H over so they could destroy the tablet together. The DON stated RN G and LVN H did not document on the narcotic sheet that they destroyed 1 tablet together as they were supposed to. The DON stated RN G was called to a meeting by administration leaving LVN H to administer 1 tablet to the resident. The DON stated LVN H then administered 1 tablet to the resident but failed to document it in the narcotic sheet. The DON stated the Acetaminophen-Codeine medication was administered 12 more times to Resident #110 without any nurse reporting the count was off between the narcotic sheet and blister pack. The DON stated it was important to ensure narcotic sheets matched blister packs to ensure all medications were accounted for. The DON stated this medication was a controlled substance and could be abused and impair judgement in people that use them inappropriately.<br><br>In an interview with RN G at 11:19 AM on 04/24/26, RN G stated on 12/03/25 Resident #110 complained of pain. RN G stated she went to pop 1 tablet of Acetaminophen-Codeine 300-30 MG for<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #110's pain but accidentally dropped the tablet on the floor. RN G stated she called LVN H over so they could destroy the medication together as per facility policy. RN G stated she dropped the tablet in the drug buster bottle to destroy it. RN G stated she was then called to the DON's office for an unrelated issue. RN G stated she never signed the narcotic sheet for the tablet she popped out of the blister pack and destroyed. RN G stated it was important to keep an accurate log of medications to eliminate medication errors. RN G stated this medication was a controlled substance and could be abused and impair judgement in people that use them inappropriately.<br><br>In an interview with LVN H at 11:39 AM on 04/24/26, LVN H stated she witnessed the destruction of 1 tablet of Acetaminophen-Codeine 300-30 MG on 12/03/25 with RN G. LVN H stated RN G was then called away to go talk to the DON about something unrelated. LVN H stated she then popped 1 tablet out of the blister pack and administered it to Resident #110 for her pain. LVN H stated she did not sign the narcotic book for either the destruction of 1 tablet or the administration of the other tablet. LVN H stated it was important to keep an accurate log of medications to eliminate medication errors. LVN H stated this medication was a controlled substance and could be abused and impair judgement in people that use them inappropriately.<br><br>Record review of Resident #16's face sheet, dated 04/22/2026, revealed a [AGE] year-old male with an original admission date of 02/02/2025, and a current admission date of 06/30/2025. Resident #16's pertinent diagnoses included Dementia with other Behavioral Disturbances (a condition which affects memory, thinking, and the ability to perform daily activities, as well as could include symptoms such as agitation, aggression, delusions, and/or hallucinations) and Anxiety (intense, excessive and persistent worry and fear about everyday situations).<br><br>Record review of Resident #16's Quarterly MDS assessment, dated 03/09/2026, revealed Resident #16 had a BIMS of 00, which indicated severely impaired cognition. The MDS also revealed Resident #16 exhibited physical behaviors toward others, verbal behaviors toward others, and other behaviors not directed toward others.<br><br>Record review of Resident #16's care plan, initiated 02/06/2026, revealed Resident #16 uses anti-anxiety medication. Interventions included give anti-anxiety medications as ordered by the physician. Monitor and document the side effects and effectiveness of the medication.<br><br>Record review of Resident #16's physician order summary, dated 12/31/2025, revealed apply Ativan 1 MG / 2 ML every 8 hours topically to wrist.<br><br>Record review of Resident #16's March 2026 and April 2026 MAR revealed Resident #16's Ativan 1 MG / 2 ML was checked as administered every 8 hours up until 04/22/2026 (date of survey).<br><br>Record review of Resident #16's Ativan Controlled Count Sheets revealed only one syringe, to equal 0.5 MG / 1 ML, was administered every 8 hours beginning 03/07/2026 – 04/22/2026.<br><br>In an observation on 04/22/2026 at 3:20 PM of the 400 Hall Nurse med-cart, there were two zip-lock bags full of 1 ML syringes prefilled with 0.5 MG of topical Ativan in each syringe. The two bags combined contained 17 prefilled syringes for Resident #16.<br><br>In an interview on 04/22/2026 at 3:25 PM, LVN-A initially stated Resident #16 was only supposed to have gotten one, 1 ML syringe of topical Ativan every 8 hours, but after reviewing the order and looking at the syringes, he stated the syringes were only 0.5 MG per 1 ML syringe, so Resident #16 (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | needed two syringes each time to equal the correct dosage. He stated he, as well as other nurses, had been giving the medication incorrectly, and Resident #16 was only getting half of the ordered dosage each time. He stated the medication was being utilized for Resident #16's anxiety and behaviors. He stated his behaviors were being controlled for the most part by the partial dosage, and he had not seen Resident #16 have any increase in behaviors or anxiety.<br><br>In an interview on 04/22/2026 at 3:30 PM, after reviewing the order and looking at the syringes and the controlled count sheets, the DON stated Resident #16 was supposed to be getting 1 MG / 2 ML of topical Ativan, but he had only been getting 0.5 MG / 1 ML of topical Ativan every 8 hours. She stated Resident #16's Ativan was prescribed for anxiety and behaviors. She also stated although his anxiety or behaviors had not changed or increased in severity, they could have since he was not getting the appropriate prescribed dose of the medication.<br><br>Attempted to interview Resident #16 on 04/22/2026 at 3:40 PM. Resident #16 was unable to answer questions.<br><br>Record review of the facility's Medication Administration Policy, no date identified, revealed Policy: Medications are administered as prescribed. 16. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. if there is any reason to question the dosage or direction, the physician's orders are checked for the correct dosage schedule. Checklist for completing proper steps in the administration of medication: Adheres to the 6 Rights of Medication Administration: 1) Right Dose, 2) Right Route, 3) Right Resident, 4) Right Medication, 5) Right Time, 6) Right Documentation.<br><br>Record review of the facility policy Controlled Medications – Administration last revised 04/06/26 revealed the following policy:<br><br>.6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record:<br><br>Date and time of the administration<br><br>Amount administered<br><br>Signature of the nurse administering the dose, completed after the medication is actually administered.<br><br>7. When a dose of controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. If allowed by your state, they may be destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose.<br><br>8. At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or nurse and a CMA, QMAP, Med Tech or equivalent as allowed by your State regulatory agency and is documented on an audit record. Alternatively, the shift change audit may be recorded on the accountability record if there is a designated column for the audit. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation in that: The facility failed to ensure the juicer's dispenser nozzle was clean. This failure could place residents at risk of foodborne illnesses. Findings included: During an observation of the kitchen on 04/22/26 at 10:25 a.m., the juicer's dispenser nozzle had a reddish slimy film in the middle of the nozzle and a hardened yellowish crust that had formed around the nozzle. During an interview on 04/22/26 at 10:27 a.m., [NAME] F said the juicer including the nozzle were cleaned every day. She said the juicer had been used earlier in the day, and that was probably why it was dirty. She tried to remove the yellowish crust but was not able. She could not say how not cleaning the juicer nozzle could negatively affect residents. During an interview on 04/24/26 at 9:35 a.m., DA E said it was the responsibility of all kitchen staff to ensure the kitchen was clean. She said at the end of each shift all kitchen staff were responsible for cleaning their assigned area. She said dietary aides were responsible for cleaning the juicer, which included the nozzle on a daily basis. DA E said she cleaned the juicer on a daily basis but had failed to leave the nozzle soaking in water as she was supposed to. She was not able to say how not cleaning the juicer nozzle could negatively affect residents. Record review of the facility's kitchen Daily Cleaning Scheduled for week ending 04/18/26 and 04/25/26 reflected DA E had cleaned juicer for the past two weeks. During an interview on 04/24/26 at 9:45 a.m., the DM said part of her responsibilities was to ensure the kitchen was clean. She said she had a cleaning log that included all kitchen appliances which included the juice machine. She said all kitchen staff were assigned to clean the appliances on a daily basis. The DM said the juicer nozzle was to be left soaking in water overnight on a daily basis. She said, I'm going to be honest with you, I had not been checking the juicer nozzle to make sure it was clean, I might have overlooked it. She said the negative outcome of not having a clean juicer/nozzle could be foodborne illnesses. Record review of facility's undated Cleaning Schedules policy reflected: The dietary department and all equipment in the dietary department will be cleaned on a regular scheduled basis. Procedure: 3. It is the responsibility of all employees to follow the cleaning schedule, and to initial their assignments when completed. 5. Cleaning schedules are to be individualized to the facility, and it is the responsibility of the DSM to ensure that the assigned tasks are completed when assigned, and in a thorough manner. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 (Resident #83) residents reviewed for respiratory care. The facility failed to ensure Resident #83's oxygen was administered on 04/23/26 as ordered by the physician. This deficient practice could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #83's admission record, dated 04/23/26, reflected a [AGE] year-old female with an admission date of 02/07/25. Her relevant diagnoses included Alzheimer's disease (a progressive, irreversible neurodegenerative disorder), shortness of breath (the uncomfortable feeling of not getting enough air), and anxiety (mental health condition characterized by excessive, persistent worry and fear that interferes with daily life). Record review of Resident #83's annual MDS assessment, dated 02/20/26, reflected her BIMS score was left blank, which reflected her cognition was severely impaired. Record review of Resident #83's quarterly care plan, dated 04/22/26, reflected [Resident #83] has oxygen therapy, ineffective gas exchange. Date initiated 04/06/26. Interventions included: oxygen at 2 LPM per nasal cannula. Date initiated 04/06/26. Record review of Resident #83's physician summary order, dated 04/23/26, reflected Resident #83 had an order for oxygen LPM: 2 LPM via: nasal cannula, every shift related to shortness of breath with start date of 02/24/26. During an observation on 04/23/26 at 8:06 a.m., Resident #83 was observed lying in bed awake. She had a nasal cannula on, and the concentrator was set at 2.5 lpm. During an interview and observation on 04/23/26 at 8:14 a.m., LVN B was observed as she checked Resident #83's oxygen setting on the concentrator and said it was set at 2.5 lpm. LVN B was observed as she reviewed Resident #83's electronic medical record and said Resident #83 had an O2 order for 2 lpm continuously via nasal cannula. LVN B said her shift had started at 6:00 a.m. but had not checked on Resident #83 yet. LVN B was observed as she checked Resident #83's oxygen using a pulse oximeter and registered at 99%. LVN B said there were no negative outcomes to Resident #83 having her O2 setting at 2.5 instead of 2 lpm as ordered. During an interview on 04/23/26 at 8:14 a.m., the DON said it was the nursing staff's responsibility to ensure a resident's O2 settings were set according to their order. She said nursing staff were supposed to check a resident's O2 settings each time they went into a resident's room. She said Resident #83 had an order for continuous O2 via nasal cannula at 2 lpm. The DON said a negative outcome to Resident #83 not having her O2 set as ordered could be too much oxygen. The DON said nursing staff were regularly in-serviced on oxygen administration. Record review of the facility's Oxygen Administration policy undated, reflected: Oxygen therapy includes the administration of oxygen (O2) in liters/minute (1/min) by cannula or face mask to treat hypoxemic (condition characterized by abnormally low levels of oxygen in the arterial blood) conditions caused by pulmonary or cardiac disease. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. The nasal cannula delivers 22-40 % oxygen and is the most common, inexpensive, and easiest device to use. Common oxygen sources for long-term administration include a cylinder (portable or stationary) or wall system near the resident's bed or concentrator. Goals: 1.The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles 1 of 6 medication carts (Med Aide Cart 1) reviewed for storage. The facility failed to keep Med Aide Cart 1 locked when MA I stepped into room [ROOM NUMBER] to measure a resident's blood pressure during med pass at 7:51 AM on 04/23/26. The failure could place residents in the facility at risk of drug diversion or misuse of medications leading to harm.Findings included:During an observation at 7:51 AM on 04/23/26, Med Aide Cart 1 was unlocked in front of room [ROOM NUMBER]. MA I was inside room [ROOM NUMBER] measuring a resident's blood pressure for approximately 2 minutes, when she came back out of the room at 7:53 AM and noticed she left the medication cart unlocked. During an interview with MA I at 8:45 AM on 04/23/26, MA I stated she was supposed to keep the cart locked whenever she entered a resident's room to check their blood pressure or administer medications. MA I stated if a cart was left unlocked and unsupervised another resident or visitor could have opened the cart and taken medication. During an interview with the DON at 10:41 AM on 04/24/26, the DON stated med aides and nurses should lock their carts before entering a resident's room to check blood pressure or administer medications. The DON stated it was important to keep the cart locked when not supervised to prevent any unauthorized individual from accessing the medication in the cart. Record review of the undated facility policy titled Medication Storage in the Facility revealed the following: .2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g. medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for 1 (Resident #101) of 3 residents. The facility failed to ensure Resident #101's facility death on [DATE], was accurately documented on his electronic medical record. This failure could place residents at risk of errors by staff when reading information in the clinical record that was inaccurate or incomplete.Findings included: Record review of Resident #101's admission record, dated [DATE], reflected an [AGE] year-old male with an admission date of [DATE] and a discharge date of [DATE]. His relevant diagnoses included chronic obstructive pulmonary disease (a progressive, irreversible lung disease causing restricted airflow and severe breathing difficulties), dementia (progressive decline in mental ability-including memory loss, confusion, and behavioral changes), and seizures (sudden, temporary busts of abnormal electrical activity in the brain). Record review of Resident #101's admission MDS assessment, dated [DATE] reflected a BIMS score of 06, which indicated his cognition was severely impaired. Record review of Resident #101's death in facility MDS assessment dated [DATE], reflected Discharge Status, deceased . Record review of Resident #101's comprehensive care plan dated [DATE], reflected [Resident #101] has an order for Do Not Resuscitate (DNR). Date initiated [DATE]. Interventions included in the absence of b/p, pulse, respirations, and CPR will not be initiated. Date initiated [DATE]. Record review of Resident #101's progress notes reflected the last entry was done on [DATE]. There was no documentation indicating Resident #101's expiration and the action taken on [DATE]. Record review of Resident #101's Death Notice dated [DATE] indicated his remains were released to a local mortuary at 10:29 p.m. signed by Hospice Nurse. During an interview on [DATE] at 9:56 a.m., LVN D said the facility's protocol was when a resident expired in the facility the nursing staff were responsible to thoroughly document how the resident was found, who found them, the presence or absence of vital signs, the resident's code status, all assessments, and actions taken, who was notified, the time of death, and to whom the body was released. LVN D could not say what the negative outcome of not documenting a resident's death on their electronic medical record was but did say, we have to document it. During an interview on [DATE] at 3:22 p.m., the DON said Resident #101 was a hospice resident and had a code status of DNR. The DON said whenever a resident expired in the facility, it was the nursing staff responsibility to document who had found the resident, how they were found, their vital signs if present or not, their code status, all assessment and actions taken, who was notified, their time of death, and to whom the body was released. The DON said nursing staff were regularly in-serviced on the topic of documentation. The DON said the negative outcome of not thoroughly documenting a resident's death in the facility would be that there would be no record of what happened. Record review of the facility's undated Pronouncement of Death policy reflected, Procedure for RN: 3. The nurse will notify the attending physician.Document the date, time, and the physician's statement at notification. Record review of the facility's undated Documentation policy reflected: Documentation is the recording of all information, both objective and subjective in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the resident involving care and treatment. It has legal requirements regarding accuracy and completeness, legibility, and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes. Goal: 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed. Procedure: 3. Document identifying and statistical information on the proper form or utilizing electronic medical record. 4. Document completed assessments in a timely manner. 5. Complete documentation as needed in a timely manner |