STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676479	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richard A. Anderson (State of Texas Veterans Land	14041 Cottingham Road Houston, TX 77048

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16989 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 18%, based on 5 errors out of 27 opportunities, which involved 1 of 4 residents (Resident #1) and 1 of 3 staff (MA A) observed during medication administration reviewed for medication error, in that: -MA A administered the incorrect dose of Chlor-Con (potassium chloride) to Resident #1. -MA A failed to administer 4 additional medications/supplements prior to surveyor intervention. -MA A had documented she administered the 4 medications/supplements. -The resident did not receive the medications/supplements until after surveyor intervention. These failures placed the resident at risk for inadequate therapeutic outcomes, increased negative side effects, and a decline in health. Findings include: Record review of the Admission Record (copied 08/22/24) for Resident #1 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, congestive heart failure, atrial fibrillation (irregular heartbeat), hypokalemia (low potassium), type 2 diabetes mellitus, GERD (reflux disease), and arthritis. Record review of the admission MDS assessment dated [DATE] for Resident #1 revealed he scored 14 of 15 on the BIMS, indicative of intact cognition. Record review of the Care Plan dated 07/02/24 for Resident #1 revealed he was at risk for complications from atrial fibrillation. One intervention was reflected as Medications as ordered. Observation on 08/22/24 at 8:05 a.m. revealed MA A was at her medication cart near the entrance to Resident #1's room. Her computer screen displayed the orders for Resident #1's morning medications. Observation revealed MA A dispensed the following medications/supplements into a transparent 30 cc medication cup: Lasix 40 mg (diuretic) 1 tablet (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Jardiance 10 mg (for diabetes) 1 tablet Klor-Con 10 meq (potassium chloride) 1 tablet Toprol 25 mg (for blood pressure) 1 tablet Famotidine 20 mg (for GERD) 1 tablet Ranolazine ER 500 (for chest pain) 1 tablet Allopurinol 100 mg (for gout) 1 tablet Tamulosin 0.4 mg (for urinary retention) 1 tablet Aspirin 81 mg 1 tablet Continued observation revealed MA A closed the drawers of the medication cart and locked it. The surveyor asked her to count the number of medications in the cup. MA A counted the medications and said Nine. MA A administered the nine medications to Resident #1. Record review of Resident #1's August 2024 Physician's Orders revealed the resident was to receive 20 meq of potassium chloride, but was administered 10 meq. Continued review of the Orders revealed he was to receive CoQ10 100 mg (for congestive heart failure), a multivitamin, and Calcium 600 mg + vitamin D3 20 mcg (for vitamin deficiency). Those medications/supplements had not been administered. Record review of a Physician's Order dated 08/13/24 revealed Resident #1 was to receive Fexofenadine HCl 60 mg (for allergies) twice daily. The medication had not been administered. Record review on 08/22/24 at 9:00 a.m. of Resident #1's August 2024 MAR revealed MA A had initialed and checked that she had administered the CoQ10 100 mg tablet, the multivitamin, the Calcium 600 mg + vitamin D3 20 mcg, and the Fexofenadine HCl 60 mg. A copy of the MAR was made at that time. In an interview on 08/22/24 at 09:12 a.m., Resident #1 was asked if MA A had returned with additional medications. The resident said MA A had returned to let him know when he could receive a pain medication from the nurse, but she did not bring any additional medications. In an interview and observation on 08/22/24 at 09:15 a.m. MA A said she had given all of the 9:00 a.m. scheduled medications to Resident #1. The surveyor asked her to check the order for the Potassium Chloride. MA A checked the order on the computer and verified it was for 20 meq. She looked at the medication 'blister pack' which had 10 meq tablets. MA A said, Clor-con is 20. It's a 10. I need to give him another one. Observation revealed MA A dispensed and administered a 10 meq tablet to the resident. Record review on 08/22/24 at 1:00 p.m. of Resident #1's August 2024 MAR revealed the CoQ10 100 mg tablet, the multivitamin, the Calcium 600 mg + vitamin D3 20 mcg, and the Fexofenadine HCl 60 mg had been changed to a '9' (not given) instead of a check indicating they were given. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/22/24 at 1:10 p.m., RN B, the Unit Charge Nurse, was asked if MA A had informed her that a resident did not receive all of his medications. RN B said that MA A did not tell her she did not give some medications, but asked her to 'strike out' medications for Resident #1. She said MA A did not give a reason, and she did not ask her why. She said MA A had left the facility. In an interview on 08/22/24 at 1:40 p.m., ADON C said MA A had informed her that Resident #1 did not receive the Calcium with Vitamin D, the CoQ10, and the Fexofenadine. She said she looked at the MAR and they were coded '9', which meant the nurse was verbally informed. ADON C said she could not recall the time MA A informed her. ADON C said that she went to Central Supply, and the medications/supplements were there. The Pharmacy nurse then administered them. The surveyor informed ADON C the MAR had been signed as 'given,' then changed to a code '9'. ADON C said MA A should not have signed them as given. Record review of the the facility policy Medication Administration (no date) read, in part, .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection . Review MAR to identify medication to be administered .Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time .Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.