

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Kent County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1443 North Main Jayton, TX 79528	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849</p> <p>Based on interviews and record review the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of controlled medications for 2 of 6 residents (Residents #1 and #2) reviewed for pharmaceutical services.</p> <p>The facility failed to ensure that the MA accurately documented the narcotic count sheet for Resident #1's scheduled pain medication administration for Norco 5-325 mg.</p> <p>The facility failed to ensure the MA followed the physician's orders for Resident #1's scheduled pain medication administration for Norco 5-325 mg.</p> <p>The facility failed to ensure that LVN B documented the narcotic count sheet for Resident #2's scheduled pain medication for Norco 7.5-325mg.</p> <p>These failures could place residents at risk of having their medications diverted or missing.</p> <p>Findings included:</p> <p>Record Review of Resident #1's face sheet, dated 8/5/24 revealed Resident was a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: dementia (memory loss), muscle weakness, depression, insomnia, hypertension (high blood pressure), osteoarthritis, and pain in unspecified joint.</p> <p>Record review of Resident #1's MDS, dated [DATE] revealed a BIMS score of 8 that indicated Resident #1 had moderately impaired cognition.</p> <p>Record Review of Resident #1's care plan, revised date 4/24/24, revealed the following focus areas: Limited physical mobility related to pain, osteoarthritis, and pain medication therapy with medication-Hydrocodone/Acetaminophen. Interventions included administer medications as ordered by the physician, monitor/document side effects, and effectiveness.</p> <p>Record Review of Resident #1's Physician order, dated 6/5/24 revealed a medication order of Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen), give 1 tablet by mouth every 8 hours related to pain in unspecified joint, unspecified osteoarthritis.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #1's Individual Patient Narcotic Record for Hydroco/APAP 5/325mg, documented that on 8/4/24 at 0500 AM LVN A signed out 1 tab for Resident #1 leaving a count of 104. The next entry signed by MA on 8/4/24 revealed that MA signed out 1 tab and entered a count of 103. The time entry of 6:00 a.m. had been written over and was not legible to determine if it was changed to 1200 p.m. or 2 p.m. The next entry revealed no time or date signed by MA with the words correct count of 102 initialed by LVN A.</p> <p>Record Review of Resident #1's Medication Administration Record (MAR) revealed, Medication: Norco Oral tablet 5-325mg (Hydrocodone-Acetaminophen) Give 1 tab by mouth every 8 hours related to pain in unspecified joint, unspecified osteoarthritis, start date 6/5/24: On 8/4/24 at 5:00 a.m. the medication was administered by LVN A, on 8/4/24 at 2:00 p.m. the medication was administered by the MA. No documented entry for 8/4/24 at 6:00 a.m. by MA.</p> <p>Record Review of Resident #1's progress notes, dated 8/4/24 at 6:28 p.m. by LVN A revealed: Upon SN arrival to work, SN was informed by med aid that after this SN gave resident her routine Norco 5-325 mg @ 0500 [5 am], med aid informed SN that she had accidentally gave resident another dose @ 0600 [6 am], DON made aware. Resident displays no adverse reactions without resp distress noted VS 136/74 78 18 97.6 96 RA.</p> <p>Record Review of Resident #2's face sheet, dated 8/5/24 revealed Resident was a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Heart failure, other chronic pain, pain in right shoulder, gout, osteoarthritis, generalized anxiety disorder, and major depressive disorder.</p> <p>Record Review of Resident #2's MDS dated [DATE] revealed a BIMS score of 15 that indicated intact cognition.</p> <p>Record Review of Resident #2's care plan, revised date 4/29/24 revealed the following focus areas: Arthritis of the lower back and hands, chronic pain related to age and arthritis, frequent gout flare ups, and receives medication for pain control. Interventions included give gabapentin, Norco, allopurinol, and Tylenol as ordered by the physician. Monitor and document for side effects and effectiveness.</p> <p>Record Review of Resident #2's physician order, dated 7/24/23 revealed a medication order of Norco Oral Tablet 7.5 325 mg (Hydrocodone-Acetaminophen), give 1 tablet by mouth four times a day related to other chronic pain.</p> <p>Record Review of the Individual Patient Narcotic Record for Resident #2 Hydroco/APAP 7.5/325mg, revealed that the last documented dose of 1 tab was logged by LVN B on 8/5/24 at 6:35 a.m. with a remaining count of 56.</p> <p>Record Review of Resident #2's Medication Administration Record (MAR) revealed, that LVN B administered Norco to Resident #2 on 8/5/24 at 7:00 am and at 12:00 p.m.</p> <p>During an interview on 8/5/24 at 10:15 a.m. Resident #1 stated that she received her medications and had no issues regarding medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/5/24 at 1:51 p.m. the DON stated that on 8/4/24 the MA gave Resident #1 a dose of Norco 5-325 at an unknown time. The DON stated that the MA documented the 2 p.m. dose into the MAR but did not document it on the narcotic count sheet. The DON stated that due to the MA's errors there were 2 medication errors. The DON stated that both LVN A and MA were not currently in the building. The DON stated she would provide phone numbers for LVN A and the MA.</p> <p>During a controlled medication count for medication cart 1 on 8/5/24 at 2:15 p.m. with LVB B revealed that Resident #2's Individual Patient Narcotic Record for Hydroco/APAP 7.5/325mg, documented a remaining count of 56. Resident #2's medication card for Hydroco/APAP 7.5/325mg revealed a count of 55 remaining pills.</p> <p>During an interview on 8/5/24 at 2:27 p.m. LVN B stated that she did not log Resident #2's Hydrocodone on controlled substance/narcotic count sheet when she administered it at 1:00 p.m. on 8/5/24. LVN B stated that the count was off on the sheet. LVN B stated that she had been trained on medication administration and to verify the right resident, right route, date of birth, log it out of the narcotic book, and log into the MAR. LVN B stated I couldn't tell you why I didn't log that one. I guess I got into a hurry. LVN B stated that she would have found the error when she went to administer the 3 p.m. dose to Resident #2. LVN B stated that it was important to log it on the narcotic sheet because the next staff member would had thought that Resident #2 did not receive the dose and could have given Resident #2 an extra dose. LVN B stated that she did log it on the MAR. LVN B stated that if a resident received an extra dose it could result in the resident feely drowsy, falls, or confusion. LVN B stated that at shift change the nurses or medication aids count the narcotics to verify the count. LVN B stated if the count was off in the book, staff would conduct another count, and notify the DON. LVN B stated that staff were not permitted to leave the building until the DON conducted her investigation.</p> <p>During an interview on 8/5/24 at 2:40 p.m. with the DON and LVN B; the DON stated that LVN B did not have the controlled substance logbook when she administered the medication to Resident #2 because she (the DON) had the book at the time. The DON stated that LVN B should not have administered the medication to Resident #2 because LVN B could not verify the count and could not log that she removed a pill from the cart for Resident #2. The DON stated that although LVN B documented that she administered the pain medication to Resident #2 in the MAR, she did not follow policy and procedure because she did not have the controlled substance logbook.</p> <p>During an interview on 8/5/24 at 3:01 p.m. Resident #2 stated that her Norco pain medication was scheduled throughout the day, and she has never missed a dose. Resident #2 stated she received her dose this afternoon after lunch and had no issues with pain medication or receiving her medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/5/24 at 3:40 p.m. the DON stated that when an additional dose of Norco was administered to a resident there was always a risk that a resident could have complications such as death, respiratory failure, fatigue, or falls. The DON stated that Resident #1 was only on a 5-325mg dose of Norco which was not enough to cause death or respiratory failure. The DON stated that the MA should have immediately notified her that she gave Resident #1 an additional dose of Norco one hour after LVN A did. The DON stated that if she had been notified, the physician would have been immediately notified, and Resident #1 would have been monitored for signs and/or symptoms in addition to monitoring of her vital signs. The DON stated that LVN B could have forgotten that she gave the dose when she failed to log it on the count sheet and could have given another dose due to her not logging it on the count sheet. The DON stated that none of these people are new and that the MA was an agency medication aid before she was hired by the facility. The DON stated that both LVN B and the MA know how to properly administer and log medications in the MAR and on the controlled substance logs. The DON stated that there was no excuse for the MA not reporting to the nurse or to her that she had given Resident #1 an additional dose.</p> <p>During a phone interview on 8/6/24 at 7:00 am, MA stated, I gave [Resident #1] an extra dose of her Norco on 8/4/24 at 6a.m. I did not look at the MAR in the computer. I did not inform anyone that I gave the extra dose until we did the med count at 6pm. I had been trained on how to properly give medications, to check the MAR first before pulling the medication from the cart, verifying the correct count, and logging the dose into the MAR and count sheet. I just didn't do that. What are you trying to accuse me of? I didn't look at the computer to check first. That was my bad. Due to the MA becoming defensive during the interview, this INV thanked MA for her time and MA terminated the call.</p> <p>During a phone interview on 8/6/24 at 10:00 LVN A stated that they work the 6 p.m. to 6 a.m. shift. LVN A stated that on 8/4/24 they gave Resident #1 a dose of Norco at 5 a.m. LVN A stated when they returned to the 6 p.m. shift on 8/4/24, Resident #1's count sheet for Norco 5/325mg was off one pill. LVN A stated that the MA stated that she accidentally gave Resident #1 another dose on 8/4/24 at 6 a.m. and it was documented on the count sheet. LVN A stated that on that entry by the MA, the count was correct, but the MA did not document that the 2 p.m. dose was given on the count sheet. LVN A stated that the DON was notified that the count was off and advised them to do a correct count. LVN A stated that another entry was written by MA correcting the count to match the number of pills remaining and LVN A stated they initialed it. LVN A stated that all staff who administer medications were trained to document on the controlled count sheet and to enter the medication administration in the MAR. LVN A stated that by the MA not documenting that she administered the extra dose to Resident #1, it could have caused adverse effects cause Resident #1 to be drowsy or staff to possibly give the next dose.</p> <p>During a phone interview on 8/9/24 at 9:52 a.m. LVN C stated that she worked on 8/4/24 from 6 a.m. to 6 p.m. and was not notified by the MA that the MA gave Resident #1 an extra dose of Norco 5/325mg an hour after LVN A administered it. LVN C stated that at the end of the shift during a count of the narcotics it was revealed that a pill was missing from Resident #1's Norco packet and was not logged on the control count sheet. LVN C stated that the MA stated that she gave Resident #1 a dose at 6 a.m. in error. LVN C stated that had the MA checked the MAR, it would have indicated that Resident #1 received the dose by LVN A. LVN C stated that staff were trained how to properly administer medications, to check the count sheet and pills left to verify they match, and to document administration in the MAR. LVN C stated that the MA should not have administered the extra dose to Resident #1 because Resident #1 could have been lethargic, had lowered blood pressure or a fall.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of facility provided policy, Administering Medications, dated April 2019 revealed in part: Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame.</p> <ol style="list-style-type: none"> 1. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. 2. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 3. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 4. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: <ol style="list-style-type: none"> a. the date and time the medication was administered. b. the dosage. c. the route of administration. d. the injection site (if applicable). e. any complaints or symptoms for which the drug was administered. f. any results achieved and when those results were observed; and g. the signature and title of the person administering the drug. <p>Record Review of the facility provided policy, Controlled Substances, revised December 2012, revealed in part: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of Schedule II and other controlled substances. Nursing staff must count controlled medications at the end of each shift. The nursing coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849</p> <p>Based on interviews and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 6 residents (Resident #1) reviewed for medication administration.</p> <p>The facility failed to ensure the MA followed the physician's orders for Resident #1's scheduled pain medication administration for Norco 5-325 mg when she administered a dose one hour after Resident #1 received the previous dose.</p> <p>This failure could place residents at risk of receiving incorrect amounts of medication prescribed by their physician.</p> <p>Findings included:</p> <p>Record Review of Resident #1's face sheet, dated 8/5/24 revealed; Resident # is a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Dementia (memory loss), Muscle weakness, Depression, Insomnia, Hypertension (high blood pressure), Osteoarthritis, and pain in unspecified joint.</p> <p>Record Review of Resident #1's care plan, revised date 4/24/24, revealed the following focus areas: Limited physical mobility related to pain, Osteoarthritis and pain medication therapy with medication-Hydrocodone/Acetaminophen. Interventions include Administer medications as ordered by physician, monitor/document side effects and effectiveness.</p> <p>Record review of Resident #1's MDS, dated [DATE] revealed a BIMS score of 8 that indicated Resident #1 has moderately impaired cognition.</p> <p>Record Review of Resident #1's Physician order, dated 6/5/24 revealed a medication order of Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen), give 1 tablet by mouth every 8 hours related to pain in unspecified joint, unspecified osteoarthritis.</p> <p>Record Review of Resident #1's Individual Patient Narcotic Record for Hydroco/APAP 5/325mg, documented that on 8/4/24 at 5:00 a.m. LVN A signed out 1 tab for Resident #1 leaving a count of 104. The next entry signed by MA on 8/4/24 revealed that MA signed out 1 tab and entered a count of 103. The time entry of 6:00 a.m. had been written over and was not legible to determine if it was changed to 1200 p.m. or 2:00 p.m. The next entry revealed no time or date signed by MA with the words correct count of 102 initialed by LVN A.</p> <p>Record Review of Resident #1's Medication Administration Record (MAR) revealed, Medication: Norco Oral tablet 5-325mg (Hydrocodone-Acetaminophen) Give 1 tab by mouth every 8 hours related to Pain in unspecified joint, unspecified osteoarthritis, start date 6/5/24: 8/4/24 5:00 a.m. administered by LVN A, 8/4/24 2:00 p.m. administered by MA. No documented entry for 8/4/24 at 6:00 a.m. by MA.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #1's progress notes, dated 8/4/24 at 6:28 p.m. by LVN A revealed: Upon SN arrival to work, SN was informed by med aid that after this SN gave resident her routine Norco 5-325 mg @ 0500 [5 am], Med aid informed SN that she had accidentally gave resident another dose @ 0600 [6 am], DON made aware. Resident displays no adverse reactions without resp distress noted VS 136/74 78 18 97.6 96 RA.</p> <p>During an interview on 8/5/24 at 10:15 a.m. with Resident #1; Resident #1 stated that she received her medications and had no issues regarding medications.</p> <p>During an interview on 8/5/24 at 1:51 p.m. with the DON; stated that on 8/4/24 the MA gave Resident #1 a dose of Norco 5-325 mg one hour after LVN A gave Resident #1 the scheduled dose. The DON stated that it was not documented into the MAR and the MA did not notify any staff that she gave the extra dose. The DON stated that the MA documented the 2 p.m. dose into the MAR but did not document it on the narcotic count sheet.</p> <p>During an interview on 8/5/24 at 3:40 p.m. with the DON, the DON stated that when an additional dose of Norco is administered to a resident there is always a risk that a resident could have complications such as death, respiratory failure, fatigue or falls. The DON stated that Resident #1 was only on a 5-325mg dose of Norco which was not enough to cause death or respiratory failure. The DON stated that the MA should have immediately notified her that she gave Resident #1 an additional dose of Norco one hour after LVN A did. The DON stated that if she had been notified, the physician would have been immediately notified and Resident #1 would had been monitored for signs and/or symptoms in addition to monitoring of her vital signs. The DON stated that none of these people are new and that the MA was an agency medication aid before she was hired by the facility. The DON stated that the MA knew how to properly administer and log medications in the MAR and on the controlled substance logs. The DON stated that there was no excuse for the MA not reporting to the nurse or to her that she had given Resident #1 an additional dose.</p> <p>During a phone interview on 8/6/24 at 7:00 am, MA stated, I gave [Resident #1] an extra dose of her Norco on 8/4/24 at 6a.m. I did not look at the MAR in the computer. I did not inform anyone that I gave the extra dose until we did the med count at 6pm. I had been trained on how to properly give medications, to check the MAR first before pulling the medication from the cart, verifying the correct count, and logging the dose into the MAR and count sheet. I just didn't do that. What are you trying to accuse me of? I didn't look at the computer to check first. That was my bad. Due to the MA becoming defensive during the interview, this INV thanked CMA for her time and CMA terminated the call.</p> <p>During a phone interview on 8/6/24 at 10:00 with LVN A; stated that they work the 6 p.m. to 6 a.m. shift. LVN A stated that on 8/4/24 they gave Resident #1 a dose of Norco at 5 a.m. LVN A stated when they returned to the 6 p.m. shift on 8/4/24, Resident #1's count sheet for Norco 5/325mg was off one pill. LVN A stated that the MA stated that she accidentally gave Resident #1 another dose on 8/4/24 at 6 a.m. and it was documented on the count sheet. LVN A stated that the MA did not document that the 2 p.m. dose was given on the count sheet. LVN A stated that the DON was notified that the count was off and advised them to do a correct count. LVN A stated that another entry was written by MA correcting the count to match the number of pills remaining and LVN A stated they initialed it. LVN A stated that all staff who administer medications are trained to document on the controlled count sheet and to enter the medication administration in the MAR.</p> <p>(continued on next page)</p>		

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