| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **676144** | A. BUILDING _____ B. WING _____ | **03/24/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **SENIOR CARE HEALTH & REHABILITATION CENTER - WICHI** | **910 MIDWESTERN PKWY WICHITA FALLS, TX 76302** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving and administering medications for one (Resident ID #1) out of 5 residents reviewed for pharmaceutical services, by failing to ensure: A. the medication [MEDICATION NAME] was re-ordered in a timely manner and administered to Resident ID #1 according to physician orders [REDACTED]. The facility's failure placed residents at risk for compromised health status by not receiving medication as ordered by their physician to treat their medical condition.<br>Findings include: Resident ID #1 Review of the Resident's Face Sheet dated 03/24/20, revealed he was a [AGE] year-old male who had been re-admitted to the facility on [DATE] and his [DIAGNOSES REDACTED]. Interventions include: give [MEDICATION NAME] ([MEDICAL CONDITION] replacement therapy) as ordered; obtain and monitor lab / diagnostic work as ordered, report results to MD and follow up as indicated. Review of Resident ID #1's Medication Administration Record, [REDACTED]. Review of the Medication Administration Record [REDACTED]. On 03/22/20 the order for [MEDICATION NAME] was changed to administer the medication at 9 PM instead of 5 AM. Review of the Resident's lab results dated 03/23/20 at 8:28 AM, revealed a [MEDICAL CONDITION]-stimulating hormone (TSH) level of 1.12, with a reference range of 0.45-5.33, this indicated the TSH was within normal limits. On 03/24/20 at 9:11 AM, Resident ID #1 was observed sitting in his wheelchair in the hallway. The resident could state his name but was not able to answer any other questions and could not be interviewed. In a telephone interview on 03/23/20 at 4:38 PM, a family member of Resident ID #1 stated the resident had not been getting his [MEDICATION NAME]. The family member stated there was a camera in the resident's room. After reviewing the camera footage going back to 02/24/20 the family member noticed the resident was not being administered the [MEDICATION NAME]. The family member stated that LVN A admitted that the facility had run out of [MEDICATION NAME] 75 mcg. In an interview on 03/24/20 at 1:58 PM, the DON stated that she was notified by the family member that the resident was not getting his [MEDICATION NAME]. The DON stated that two LVNs failed to administer [MEDICATION NAME] 75 mg to the resident for 5 consecutive days. LVN A admitted to the DON that she had not administered the [MEDICATION NAME] 75 mcg to the resident as ordered on [DATE] and 03/13/20. LVN B admitted to the DON that she had not administered the [MEDICATION NAME] 75 mcg to the resident as ordered on [DATE], 03/11/20 and 03/14/20. The DON stated that neither of the LVNs followed instructions for re-ordering medications and that the medication was not in the pharmacy 03/10/20 through 03/14/20. LVN A told the DON that she had called the pharmacy but there was no record of the call. The DON stated that both LVNs failed to fill out a Pharmacy Medication Request form (med out form) for the [MEDICATION NAME] 75 mcg. The DON stated that both LVNs could have used Point Click Care secure messaging to notify the DON or ADONs to get the medication refilled in the pharmacy. The DON stated that both LVNs were written up for medication errors. The DON stated that the pharmacy told her the [MEDICATION NAME] was not in the roll of medications for the resident because the pharmacy wanted to know what Hospice was going to cover. The resident was newly admitted to Hospice upon discharge from hospital on [DATE]. |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.