| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **675229** | A. BUILDING _____ B. WING _____ | **04/21/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **WOODLAND MANOR NURSING AND REHABILITATION LP** | **99 RIGBY OWEN RD CONROE, TX 77304** |

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 -** Some | **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 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for 2 (Resident #4 and #7) of 5 residents reviewed for pharmacy services. -The facility failed to administer [MEDICATION NAME], a nerve pain and [MEDICAL CONDITION] medication, to Resident #7 for twelve days because it was not available in the facility. -LVN B failed to administer [MEDICATION NAME], an anti-gas medication to Resident #7 because it was not available in the facility. -LVN A failed to administer [MEDICATION NAME], a medication used to prevent blood clots, to Resident #4 because it was not available in the facility. -LVN A failed to administer the correct strength of Vitamin D to Resident #4. -LVN A failed to administer the correct stool softener medication to Resident #4. These failures could affect any resident who was dependent on staff for medication administration. Findings included: Resident #7 Record review of Resident #7's face sheet revealed he was a [AGE] year-old male admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #7's quarterly MDS dated [DATE] revealed a BIMS of 6 indicating severe cognitive impairment. He required supervision with setup help for transfers, dressing, eating, toilet use, and personal hygiene. Record review of Resident #7's care plan revised on 3/10/20 read in part, . Problem . at risk for injury R/T ([MEDICAL CONDITIONS] disorder) . Approach . administer my medication as ordered by MD . Record review of Resident #4's Physician order [REDACTED]. [MEDICATION NAME] 80 mg oral tablet chewable 1 tablet chew 3 times daily, order date 4/13/20 . [MEDICATION NAME] 50 mg po one tablet three times a day, start date 3/26/20 . Observation and Interview on 4/14/20 at 1:01 p.m. with LVN B as she prepared Resident #7's afternoon medications. She prepared and administered: [MEDICATION NAME] 50 mg, [MEDICATION NAME]-[MEDICATION NAME] 5/325 mg, [MEDICATION NAME] 5 mg, [MEDICATION NAME] 3 mg,[MEDICATION NAME] 36,000 U, [MEDICATION NAME] 100 mg, and [MEDICATION NAME] 100 mg. LVN B searched for [MEDICATION NAME] 80 mg on the nursing cart and in the medication room. The medication was not available in those areas. She said pharmacy would have to deliver the [MEDICATION NAME]. Record review of Resident #7's Medications Flowsheet/MAR dated 3/1/20-3/31/20 revealed: -[MEDICATION NAME] 50 mg three times a day was left blank on 3/30/20 at 2 p.m. and 3/31/20 at 2 p.m. -[MEDICATION NAME] was also initialed and circled by LVN B, LVN C, and other unidentified staff on the following days: 3/27/20 at 8 a.m., 2 p.m., and 8 p.m. 3/28/20 at 8 a.m., 2 p.m., and 8 p.m. 3/29/20 at 8 a.m., 2 p.m., and 8 p.m. 3/30/20 at 8 a.m. and 8 p.m. 3/31/20 at 8 a.m. and 8 p.m. Record review of Resident #7's Medications Flowsheet/MAR dated 4/1/20 - 4/31/20 revealed: -[MEDICATION NAME] 50 mg three times a day (DX: . pain) was initialed and circled by LVN B, LVN C, and other unidentified staff on following dates: 4/1/20 at 6 a.m. and 2 p.m. 4/2/20 at 6 a.m., 2 p.m., and 10 p.m. 4/3/20 at 6 a.m., 2 p.m., and 10 p.m. 4/4/20 at 6 a.m., 2 p.m., and 10 p.m. 4/5/20 at 6 a.m., 2 p.m., and 10 p.m. 4/6/20 at 6 a.m., 2 p.m., and 10 p.m. 4/7/20 at 6 a.m., 2 p.m., and 10 p.m. -[MEDICATION NAME] 80 mg oral 1 tablet chew 3 times a day was initialed and circled by LVN B on 4/14/20 for the 2 p.m. administration and initialed and circled by LVN C for the 8 p.m. administration time. Interview on 4/14/20 at 12:45 p.m. with LVN B, she said Resident #7's [MEDICATION NAME] was not given for several days because the nursing staff could not find the order to send over to the pharmacy. She said it was reported to the DON who said she would follow up on it. She said a circled initial on the MAR indicated [REDACTED]. She said LVN B or LVN C told her that Resident #7's [MEDICATION NAME] was written on the MAR, but the medication was not on the cart. She said she located the order and sent it to the pharmacy. She said she was responsible for checking all the physician orders. She was not sure what Resident #7's [MEDICATION NAME] was for. She said she reported the information to Resident #7's nurse practitioner who told her to give him the medication as soon as it came in. Interview on 4/14/20 at 4:43 p.m. with LVN C, she said she did not do anything about Resident #7's missing [MEDICATION NAME]. She said someone else reported the information to the DON. Telephone interview on 4/21/20 at 11:08 a.m. with Resident #7's NP, she said [MEDICATION NAME] was ordered for the resident's pain. Continued interview at 8:41 p.m., she said the [MEDICATION NAME] was also ordered for Resident #7's [MEDICAL CONDITION]. Telephone interview on 4/21/20 at 8:47 p.m. with Resident #7's MD, he said [MEDICATION NAME] was ordered to assist with Resident #7's pain and [MEDICAL CONDITION]. Resident #4 Record review of Resident #4's face sheet revealed he was a [AGE] year-old male admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS of 15 indicating no cognitive impairment. He was totally dependent on staff for transfers, dressing, toilet use, and personal hygiene. Record review of Resident #4's care plan revised on 3/3/20 read in part, . Problem . [MEDICAL CONDITIONS] of native coronary artery . Approach . administer medications as ordered . Problem . history/potential for constipation . Approach . medications as per orders . Problem . Vitamin deficiency . Approach . administer medications as ordered . Record review of Resident #4's Physician order [REDACTED]. Vitamin D3 ([MEDICATION NAME] (vitamin d3)) (OTC) tablet; 5,000 unit, amt: one: oral (DX: vitamin D deficiency, unspecified) once a day . start date 9/19/18 . [MEDICATION NAME] ([MEDICATION NAME]) tablet; 75 mg; amt; one; oral (DX: [MEDICAL CONDITIONS] of native coronary artery without [MEDICAL CONDITION] pectoris) once a day . start date 8/3/19 . Senna (OTC) tablet; 8.6 mg; amt; one tab; oral (DX: constipation, unspecified) once a day every other day . Observation on 4/14/20 at 9:42 a.m. with LVN A as she prepared Resident #4's morning medications for administration. The medications prepared and administered to Resident #4 were: [MEDICATION NAME] 100 mg, Multivitamin with mineral, [MEDICATION NAME] sulfate 325 mg, Folic acid 1 mg, [MEDICATION NAME] 100 mg, Losartan potassium 50 mg, Potassium ER 20 meq, Vitamin C 500 mg, [MEDICATION NAME] 10 mg, [MEDICATION NAME] 5 mg, [MEDICATION NAME] 50 mg, Dorzolamide 2% eye drops, Senna plus ([MEDICATION NAME] 50 mg and sennosides 8.6), and Vitamin d3 50,000 U. [MEDICATION NAME] 75 mg was not administered to the resident and was not available on the nurse cart, medication room, or emergency drug kit. Interview on 4/14/20 at the same time with LVN A, she said Resident #4's [MEDICATION NAME] was not available in the facility and had not arrived from the pharmacy. She said medications were sometimes taking longer to get to the facility due to COVID-19. She said she spoke with the pharmacy yesterday and they said the medication would be sent. She said she would call the pharmacy again to check the status of the medication. She said she would notify the resident's nurse practitioner. Record review of Resident #4's Medications Flowsheet/MAR dated 4/1/20 - 4/30/20 revealed: [MEDICATION NAME] 75 mg tablet once a day was initialed and circled by LVN A on 4/13, 4/14, and 4/15. It also revealed Vitamin D3 5,000 units and Senna 8.6 mg (without [MEDICATION NAME]) were to be administered once a day at 8:00 a.m. Interview on 4/21/20 at 1:25 p.m. with the DON, she said when administering medications, the nursing staff should compare the medication against the physician orders/MAR to ensure the correct medication is administered. She said medications should be available to administer but if it is not, the nurse needs to initial and circle it on the MAR indicated [REDACTED]. Interview on 4/21/20 at 2:00 p.m. with LVN A, the Surveyor informed her that she administered the wrong strength of vitamin D and the wrong stool softener to Resident #4 on 4/14/20, she said she would have to look at the MAR indicated [REDACTED]. She said when administering medications, she must verify the medication against the MAR. Interview on 4/21/20 at 2:30 p.m., the Administrator questioned the Surveyor on how she |

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.

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| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>knew the Vitamin D 50,000 U was administered. The Surveyor explained to the Administrator that when the observation was made on 4/14/20 at 9:42 a.m. of LVN A, the Surveyor also documented the medication's unique NDC number. Record review of the facility's Medication Administration: General Guidelines dated May 2016 read in part, . Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber . 9. Verify medication is correct three (3) times before administering the medication. a. when pulling medication package from med cart b. when dose is prepared c. before dose is administered . Record review of the facility's Medication Ordering and Receiving from Pharmacy Provider: Ordering and Receiving Non-Controlled Medications dated September 2010 read in part, .Procedures: . a. all new medication orders are transmitted to the pharmacy . e. new medications, except for emergency or stat medications, are ordered as follows: if the first dose of medication is scheduled to be given before the next regularly scheduled pharmacy delivery, please telephone or transmit the medication orders to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery. Timely delivery of new orders is required so that medication administration is not delayed A policy on Medication availability was requested from the DON on 4/21/20 at 2:15 p.m. but was not received prior to exit. |
| F 0760<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure that residents are free from significant medication errors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to ensure that residents were free of any significant medication errors for 1 (Resident#7) of 5 residents reviewed for medication errors. -The facility failed to administer [MEDICATION NAME], a nerve pain and [MEDICAL CONDITION] medication, to Resident #7 for twelve days because it was not available in the facility. This failure could affect any resident who was dependent on staff for medication administration. Findings included: Resident #7 Record review of Resident #7's face sheet revealed he was a [AGE] year-old male admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #7's quarterly MDS dated [DATE] revealed a BIMS of 6 indicating severe cognitive impairment. He required supervision with setup help for transfers, dressing, eating, toilet use, and personal hygiene. Record review of Resident #7's care plan revised on 3/10/20 read in part, . Problem . at risk for injury R/T ([MEDICAL CONDITIONS] disorder) . Approach . administer my medication as ordered by MD . Record review of Resident #4's Physician order [REDACTED]. [MEDICATION NAME] 50 mg po one tablet three times a day, start date 3/26/20 . Record review of Resident #7's Medications Flowsheet/MAR dated 3/1/20-3/31/20 revealed: -[MEDICATION NAME] 50 mg three times a day was left blank on 3/30/20 at 2 p.m. and 3/31/20 at 2 p.m. -[MEDICATION NAME] was also initialed and circled by LVN B, LVN C, and other unidentified staff on the following days: 3/27/20 at 8 a.m., 2 p.m., and 8 p.m. 3/28/20 at 8 a.m., 2 p.m., and 8 p.m. 3/29/20 at 8 a.m., 2 p.m., and 8 p.m. 3/30/20 at 8 a.m. and 8 p.m. 3/31/20 at 8 a.m. and 8 p.m. Record review of Resident #7's Medications Flowsheet/MAR dated 4/1/20 - 4/31/20 revealed: -[MEDICATION NAME] 50 mg three times a day (DX: . pain) was initialed and circled by LVN B, LVN C, and other unidentified staff on following dates: 4/1/20 at 6 a.m. and 2 p.m. 4/2/20 at 6 a.m., 2 p.m., and 10 p.m. 4/3/20 at 6 a.m., 2 p.m., and 10 p.m. 4/4/20 at 6 a.m., 2 p.m., and 10 p.m. 4/5/20 at 6 a.m., 2 p.m., and 10 p.m. 4/6/20 at 6 a.m., 2 p.m., and 10 p.m. 4/7/20 at 6 a.m., 2 p.m., and 10 p.m. Interview on 4/14/20 at 12:45 p.m. with LVN B, she said Resident #7's [MEDICATION NAME] was not given for several days because the nursing staff could not find the order to send over to the pharmacy. She said it was reported to the DON who said she would follow up on it. She said a circled initial on the MAR indicated [REDACTED]. She said LVN B or LVN C told her that Resident #7's [MEDICATION NAME] was written on the MAR, but the medication was not on the cart. She said she located the order and sent it to the pharmacy. She said she was responsible for checking all the physician orders. She was not sure what Resident #7's [MEDICATION NAME] was for. She said she reported the information to Resident #7's nurse practitioner who told her to give him the medication as soon as it came in. Interview on 4/14/20 at 4:43 p.m. with LVN C, she said she did not do anything about Resident #7's missing [MEDICATION NAME]. She said someone else reported the information to the DON. Telephone interview on 4/21/20 at 11:08 a.m. with Resident #7's NP, she said [MEDICATION NAME] was ordered for the resident's pain. Interview on 4/21/20 at 1:25 p.m. with the DON, she said medications should be available to administer but if it is not, the nurse needs to initial and circle it on the MAR indicated [REDACTED]. Telephone interview on 4/21/20 at 8:41 p.m. with Resident #7's NP, she said the [MEDICATION NAME] was also ordered for Resident #7's [MEDICAL CONDITION]. Telephone interview on 4/21/20 at 8:47 p.m. with Resident #7's MD, he said [MEDICATION NAME] was ordered to assist with Resident #7's pain and [MEDICAL CONDITION]. Record review of the facility's Medication Ordering and Receiving From Pharmacy Provider: Ordering and Receiving Controlled Medications policy dated 5/2016 read in part, .4. The Drug Enforcement Agency (DEA) requires that a pharmacy must have a valid prescriber signed prescription in order to dispense controlled substances .In an emergency situation, verbal authorization may be given by the prescriber to the pharmacist for a new order . A policy on Medication availability was requested from the DON on 4/21/20 at 2:15 p.m. but was not received prior to exit. |