STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676186	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE LTC PARTNERS INC	**1621 BUTLER DIMMITT, TX 79027**

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 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure residents have reasonable access to and privacy in their use of communication methods.** Based on interview and record review, the facility failed to honor resident rights with consistent delivery and privacy of resident mail received by the facility on Saturdays in that: During a confidential group interview, 10 of 10 residents stated the facility did not pass resident mail on Saturday. This failure could place any of the residents in the facility at risk of not receiving mail in a prompt and private manner and could result in a decline in the resident's psychosocial well-being and cause them to feel disconnected from family, friends, and current world issues. The findings are: During a confidential group interview on 09/22/20 at 11:30 AM, all Residents stated that they do not receive mail on Saturdays. During an interview on 09/23/20 at 08:22 AM, AD said that she does not deliver mail on Saturday because she is not here. The mail is held for 2 days before delivered because of COVID. She confirmed that would make Thursday mail to be delivered on Saturday. During an interview on 09/24/20 at 01:27 PM, ADM stated that mail stays in his office and that AD gets it in her box and gives it out when she comes in. ADM cannot confirm that they get mail on Saturdays. Record review of an undated facility document titled Resident Rights Under Federal Law revealed: The facility shall protect and promote the rights of each resident, including each of the following rights: 20. The resident has a right to privacy in written communications, including the right to send and receive mail promptly that is unopened . . The facility was unable to provide a policy on receiving mail on Saturdays.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an assessment that accurately reflected the resident's status for 1 of 17 residents (Resident #9) whose assessments were reviewed. Resident #9's MDS assessment indicated that he was taking antidepressant medications when in fact he was not. Resident #9's MDS assessment indicated that he was not taking any antibiotics when in fact he received an antibiotic on all 7 days during the look back period. This failure to accurately assesses residents could place residents at risk of not receiving necessary care or receiving inappropriate care for their condition. Findings include: Record review of Resident #9's face sheet revealed a [AGE] year-old male with a current admitted [DATE] and [DIAGNOSES REDACTED]. Record review of Resident #9's MDS dated [DATE] revealed he had a BIMS score of 11 out of 15 indicating moderate cognitive impairment. The MDS also indicated that the resident required extensive assistance from staff members with eating, toilet use, and personal hygiene. Section N of the MDS indicated that the resident had received an antidepressant medication for 7 out of 7 days during the MDS look back period, and an antibiotic medication on 0 out of 7 days during the look back period. Record review of Resident #9's current physician orders [REDACTED]. Record review of the medication administration records for Resident #9 revealed no documentation of the resident being administered an antidepressant medication during the MDS look back period. The records also indicated that Resident #9 received [MEDICATION NAME], an antibiotic medication, on all 7 days of that look back period. During an interview with MR A on 09/24/2020 at 8:50 AM, she reported that the facility MDS coordinator is not at the facility and is working remotely from home. MR A reviewed the medical records for Resident #9 and reported that she could not find any documentation that the resident received an antidepressant during his MDS look back period for the MDS completed 09/18/2020. She further confirmed that the resident did receive an antibiotic during that time frame. During an interview on 09/24/2020 at 9:00 AM, DON reported that she did not see an antidepressant documented as being given to Resident #9 during his MDS look back period and confirmed that he did receive an antibiotic. During an interview on 09/24/2020 at 9:12 AM, DON confirmed that the MDS of Resident #9 dated 09/18/2020 was inaccurate and that it was a coding error that will be corrected. Record review of facility provided policy titled Certifying Accuracy of the Resident Assessment, dated October 2001, revealed in part: All personnel who complete any portion of the Resident Assessment (MDS 3.0) must sign and certify the accuracy of that portion of the assessment.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort by failing it incorporate the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care for 1 of 8 residents (Resident #7) reviewed for PASARR. Resident #7 had a positive PASRR screening on 08/22/19 and a PASRR II was not preformed. This deficient practice has the potential to affect residents by placing them at an increased and unnecessary risk of poor self-esteem and self-worth and poor quality of life. Finding include: Record review of Resident #7's clinical records revealed a [AGE] year-old male with an initial admitted [DATE]. His [DIAGNOSES REDACTED]. Resident #7's quarterly MDS dated [DATE] revealed a BIMS score of 11 out of 15 indicating moderate cognitive impairment. Record Review of Resident #7's PASRR Level 1 Screening, dated 08/22/19, revealed: C0100. Mental Illness - Is there evidence or an indicator this is an individual that has Mental Illness? Yes During an interview on 09/24/20 at 09:49 AM, DON stated that they could not find Resident #7's PASRR 2. During an interview on 09/24/20 at 10:11 AM, DON stated that Resident #7 had one from the previous facility but did not get a copy. She stated that it is being done today. She confirmed that he did not have one done. Record review of an undated facility document titled Policy and Procedure for PL1/PASRR/IDT/NFSS: Rationale: The facility will ensure compliance with all Phase I and II guidelines of the PASRR process for LongTterm Care.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice and the comprehensive person-centered care plan for 2 out of 17 residents (Resident #15 and Resident #19) reviewed for respiratory care. The facility failed to monitor the oxygen saturation of Resident #15 and Resident #19, who received oxygen therapy, every shift as ordered by the residents' physicians and indicated by their person-centered care plans. This failure could affect residents receiving oxygen therapy and/or respiratory care by placing them at risk for unrecognized adverse events or receiving improper care based on incomplete monitoring data. Findings include: Resident #15 Record review of Resident #15's face sheet revealed a [AGE] year-old male with a current admitted [DATE] and [DIAGNOSES REDACTED]. Record review of Resident # 15's quarterly MDS dated

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676186	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE LTC PARTNERS INC	1621 BUTLER DIMMITT, TX 79027

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 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) [DATE] revealed a BIMS score 06 out of 15, indicating severe cognitive impairment, and that he was totally dependent on staff for bed mobility, locomotion, dressing, toilet use, and personal hygiene. Record review of Resident #15's physician orders [REDACTED].#15's current comprehensive care plan revealed the following in part: Focus Oxygen Goal (Resident #15) will have adequate air exchange as evidenced by normal breathing patterns and usual mental status through the review period Interventions/Tasks Check O2 sats Q shift and as needed Focus (Resident #15) is a risk for SOB d/t [MEDICAL CONDITION] Goal He will have no complications related to SOB through the review date Interventions/Tasks Check O2 sat Q shift Record review of Resident #15's clinical records revealed no documentation that the resident's oxygen saturation was measured and/or recorded during the day shift on the dates of 09/20/2020, 09/17/2020, 09/13/2020, 09/10/2020, 09/06/2020, and 09/03/2020 during the month of September of 2020. During an observation on 09/22/2020 at 8:24 PM, Resident #15 was lying in bed and receiving oxygen by nasal cannula supplied by an oxygen concentration at 3 LPM. Resident #19 Record review of Resident #19's face sheet revealed a [AGE] year-old female with a current admitted [DATE] and [DIAGNOSES REDACTED]. Record review of Resident # 19's quarterly MDS dated [DATE] revealed a BIMS score 15 out of 15, indicating no cognitive impairment, and that she was totally dependent on staff for bed mobility, transfers, and dressing. The MDS indicated she required extensive assistance from staff with toilet use and personal hygiene. Section O of the MDS indicated that she received oxygen therapy. Record review of Resident #19's physician orders [REDACTED].#19's current comprehensive care plan revealed the following in part: Focus Asthma Goal (She will maintain normal breathing pattern as evidenced by eupnea, normal skin color, and regular respiratory rate/pattern through review date Interventions/Tasks Check and record O2 sats q shift Record review of Resident #19's clinical records revealed no documentation that the resident's oxygen saturation was measured and/or recorded during the day shift on the dates of 09/20/2020, 09/17/2020, 09/13/2020, 09/10/2020, 09/09/2020, 09/06/2020, and 09/03/2020 during the month of September of 2020. During an observation on 09/22/2020 at 8:30 PM, Resident #19 was lying in bed and receiving oxygen by nasal cannula supplied by an oxygen concentration at 3 LPM. During an interview on 09/24/2020 at 9:12 AM, DON affirmed that if something is not charted in a resident's clinical records then it wasn't done. During an interview on 09/24/2020 at 9:14 AM, MR A reviewed that clinical records of Resident #15 and Resident #19 and confirmed that there were several shifts with no documentation of their SaO2 being checked. During an interview on 09/24/2020 at 9:30 AM, DON confirmed that there were several shifts on which the SaO2 for Resident #15 was not documented. DON confirmed that the resident had a physician order [REDACTED]. Record review of facility provided policy titled Physician Orders, dated June 2004, revealed in part: Policy Statement All physician orders [REDACTED].
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess the resident for risk of entrapment from bed rails prior to installation and failed to review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 2 of 16 residents (Resident #7 and Resident #11) reviewed for Bed Rails. The facility failed to perform a bed rail entrapment assessment prior to the implementation of the bed rails for Resident #7. The facility failed to perform a bed rail entrapment assessment before the implementation of the side rails for Resident #11. This deficient practice has the potential to affect residents by placing them at an increased risk of poor self-esteem and self-worth, poor quality of life, falls, entrapment, bruising, lacerations, fractures, traumatic head injury and hanging. Findings include: Resident #7 Record review of Resident #7's clinical records revealed a [AGE] year-old male with an initial admitted [DATE]. His [DIAGNOSES REDACTED]. Resident #7's quarterly MDS dated [DATE] revealed a BIMS score of 11 out of 15 indicating moderate cognitive impairment. The clinical records of Resident #7 revealed no evidence that an entrapment risk assessment was completed for the resident prior to the installation of bedrails. During an observation on 09/23/20 at 09:08 AM, Resident #7 had 1/4-inch bed rails on his bed. Resident #11 Record review of Resident #11's clinical records revealed an [AGE] year-old female with an initial admitted [DATE]. Her [DIAGNOSES REDACTED]. Resident #11's quarterly MDS dated [DATE] revealed a BIMS score of 10 out of 15 indicating moderate cognitive impairment. The clinical records of Resident #11 revealed no evidence that an entrapment risk assessment was completed for the resident prior to the installation of bedrails. During an observation on 09/23/20 at 09:28 AM, Resident #11 had -inch bed rails on her bed. During an interview on 09/24/20 at 09:38 AM, DON confirmed that an assessment was not done on Resident #7 and Resident #11. She stated that she could not find one. During an interview on 09/24/20 at 01:02 PM, DON explained the process for bedrails which entailed getting with therapy for screening, get a doctor's order. order consent, and then assessment. Although requested, no policy for side rails was provided by the facility.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 4 of 17 residents (Resident #33) whose drug regimens were reviewed. Resident #9 was receiving an antianxiety medication ([MEDICATION NAME]) without adequate side effect monitoring as ordered by his physician. Resident #15 was receiving an antidepressant medication ([MEDICATION NAME]) and an antipsychotic medication ([MEDICATION NAME]) without adequate side effect monitoring as ordered by his physician. Resident #18 was receiving an antidepressant medication ([MEDICATION NAME]) and an antipsychotic medication (quetiapine) without adequate side effect monitoring as ordered by his physician. Resident #33 was receiving an antidepressant medication ([MEDICATION NAME]) and an antipsychotic medication ([MEDICATION NAME]) without adequate side effect monitoring as ordered by her physician. Resident # 33 was receiving apixaban (an anticoagulant medication) without adequate monitoring in that monitoring for side effects was not conducted every shift per physician orders. This failure has the potential to expose residents receiving [MEDICAL CONDITION] medications to unrecognized adverse reactions or side effects, and inappropriate treatment based on incomplete monitoring data. Findings Include: Resident #9 Record review of Resident #9's face sheet revealed a [AGE] year-old male with a current admitted [DATE] and [DIAGNOSES REDACTED]. Record review of Resident #9's MDS dated [DATE] indicated he had a BIMS score of 11 out of 15 indicating moderate cognitive impairment. The MDS also indicated that the resident required extensive assistance from staff members with eating, toilet use, and personal hygiene. Record review of Resident #9's physician orders [REDACTED].=none; 1-sedation; 2-[MEDICAL CONDITION]; 3=dizziness; 4=agitation; 5=appetite change every shift Record review of Resident #9's current comprehensive care plan revealed the following in part: Focus Antianxiety medications Goal (Resident #9) will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions/Tasks Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. Antianxiety side effects: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Paradoxical side effects: mania, hostility and rage, aggressive or impulsive behavior, hallucinations Record review of Resident #9's clinical records revealed no documentation that the resident was monitored for side effects of antianxiety medications during the day shift on the dates of 09/20/2020, 09/17/2020, 09/13/2020, 09/10/2020, 09/09/2020, 09/06/2020, and 09/03/2020 during the month of September of 2020. Resident #15 Record review of Resident #15's face sheet revealed a [AGE] year-old male with a current admitted [DATE] and [DIAGNOSES REDACTED]. Record review of Resident # 15's quarterly MDS dated [DATE] revealed a BIMS score 06 out of 15, indicating severe cognitive impairment, and that he was totally dependent on staff for bed mobility, locomotion, dressing, toilet use, and personal hygiene. Section N of the MDS indicated that Resident #15 received an antidepressant and an antipsychotic medication on 7 out of 7 days during the assessment look back period. Record review of Resident #15's physician orders [REDACTED].=none; 1=tardive dyskinesia; 2=postural [MEDICAL CONDITION]; 3=cognitive/behavior impairment; 4=parkinsonism; 5=akathisia (restless/urgent need for movement) every shift Antidepressant S/E monitoring 0=none; 1=drowsiness; 2=dizziness; 3=[MEDICAL CONDITION] 4=blurred vision; 5=[MEDICAL CONDITION]; 6=anorexia; 7=wandering; 8-other every shift Record review of Resident #15's current comprehensive care plan revealed the following in part: Focus (Resident #15) uses [MEDICAL CONDITION] medication rt [MEDICAL CONDITION] current medication: [MEDICATION NAME] Goal (He will be/remain free of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676186	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE LTC PARTNERS INC	1621 BUTLER DIMMITT, TX 79027

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 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) [MEDICAL CONDITION] drug related complications, including movement disorder, discomfort, [MEDICAL CONDITION], gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date Interventions/Tasks Administer [MEDICAL CONDITION] medications as ordered by physician. Monitor for side effects and effectiveness Q-shift. Focus (Resident #15) uses antidepressant medication [MEDICATION NAME] r/t depression Goal He will be free from discomfort or adverse reactions related to antidepressant therapy through review date Interventions/Tasks Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness Q-shift. Record review of Resident #15's clinical records revealed no documentation that the resident was monitored for side effects of [MEDICAL CONDITION] medications (including antidepressant and antipsychotic) during the day shift on the dates of 09/20/2020, 09/17/2020, 09/13/2020, 09/10/2020, 09/06/2020, and 09/03/2020 during the month of September of 2020. Resident #18 Record review of Resident #18's face sheet revealed a [AGE] year-old male with a current admitted [DATE] and [DIAGNOSES REDACTED]. Record review of Resident # 18's MDS dated [DATE] revealed a BIMS score 00 out of 15, indicating severe cognitive impairment, and that he was totally dependent on staff for transfers, locomotion, dressing, toilet use, and personal hygiene. Section N of the MDS indicated that Resident #18 received an antidepressant and an antipsychotic medication on 7 out of 7 days during the assessment look back period. Record review of Resident #18's physician orders [REDACTED].=none; 1=tardive dyskinesia; 2=postural [MEDICAL CONDITION]; 3=cognitive/behavior impairment; 4=parkinsonism; 5=akathisia (restless/urgent need for movement) every shift Antidepressant S/E monitoring 0=none; 1=drowsiness; 2=dizziness; 3=[MEDICAL CONDITION] 4=blurred vision; 5=[MEDICAL CONDITION]; 6=anorexia; 7=wandering; 8-other every shift Record review of Resident #18's current comprehensive care plan revealed the following in part: Focus (Resident #18) uses antidepressant medication for depression/mood disorder and [MEDICAL CONDITION] Goal He will be free from discomfort or adverse reactions related to antidepressant therapy through the review date Interventions/Tasks Administer antidepressant medications as ordered by physician. Monitor/document for side effects and effectiveness Q-shift. Focus (Resident #18) uses [MEDICAL CONDITION] medications Goal He will be/remain free of [MEDICAL CONDITION] drug related complications, including movement disorder, discomfort, [MEDICAL CONDITION], gait disturbance, constipation/behavioral impairment through review date Interventions/Tasks Administer [MEDICAL CONDITION] medications as ordered by physician. Monitor for side effects and effectiveness Q-shift. Record review of Resident #18's clinical records revealed no documentation that the resident was monitored for side effects of [MEDICAL CONDITION] medications (including antidepressants and antipsychotics) during the day shift on the dates of 09/20/2020, 09/17/2020, 09/13/2020, 09/10/2020, 09/09/2020, 09/06/2020, and 09/03/2020 during the month of September of 2020. Resident #33 Record review of Resident #33's face sheet revealed a [AGE] year-old female with a current admitted [DATE] and [DIAGNOSES REDACTED]. Record review of Resident #33's quarterly MDS dated [DATE] revealed she had a BIMS score 00 out of 15, indicating severe cognitive impairment, and that she requires extensive assistance from staff with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. Section N of the MDS indicated that she received an anticoagulant, antidepressant, and antipsychotic medication on 7 out of 7 days during the look back period for the assessment. Record review of Resident #33's physician orders [REDACTED].=none; 1=tardive dyskinesia; 2=postural [MEDICAL CONDITION]; 3=cognitive/behavior impairment; 4=parkinsonism; 5=akathisia (restless/urgent need for movement) every shift Antidepressant S/E monitoring 0=none; 1=drowsiness; 2=dizziness; 3=[MEDICAL CONDITION] 4=blurred vision; 5=[MEDICAL CONDITION]; 6=anorexia; 7=wandering; 8-other every shift Eliquis Tablet 5 mg (apixaban) Give 1 tablet by mouth two times a day related to [DIAGNOSES REDACTED] Anticoagulant Administration Monitor for S/S 1) Blood in Urine 2) Dark Tarry Stools 3) Blood in Emesis 4) Bleeding Gums 5) Nose Bleed 6) Bruising 7) Hematoma 8) No Sign or Symptom every shift for Eliquis Record review of Resident #33's current comprehensive care plan revealed the following in part: Focus (Resident #33) uses antidepressant medication r/t depression & [MEDICAL CONDITION] Goal She will be free from adverse reactions related to antidepressant therapy through the review date Interventions/Tasks Administer antidepressant medications as ordered by physician. Monitor/document for side effects and effectiveness Q-shift. Focus (Resident #33) uses [MEDICAL CONDITION] medications r/t [MEDICAL CONDITION], impulse disorder & mood disorder Goal She will be/remain free of [MEDICAL CONDITION] drug related complications, including movement disorder, discomfort, [MEDICAL CONDITION], gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date Interventions/Tasks Administer [MEDICAL CONDITION] medications as ordered by physician. Monitor for side effects and effectiveness Q-shift. Record review of Resident #33's clinical records revealed no documentation that the resident was monitored for side effects of [MEDICAL CONDITION] medications (including antidepressants and antipsychotics) or anticoagulant medications during the day shift on the dates of 09/20/2020, 09/17/2020, 09/13/2020, 09/10/2020, 09/06/2020, and 09/03/2020 during the month of September of 2020. During an interview on 09/24/2020 at 9:03 AM, MR A reviewed that clinical records of Resident #33 and confirmed that there were several dates with no documentation of anticoagulant or [MEDICAL CONDITION] medication side effect monitoring. During an interview on 09/24/2020 at 9:12 AM, DON affirmed that if something is not charted in a resident's clinical records then it wasn't done. DON confirmed that there were several shifts on which the anticoagulant monitoring and [MEDICAL CONDITION] medication side effect monitoring for Resident #33 was not documented. Record review of facility provided policy titled [MEDICAL CONDITION] Drug Use, dated January 2001, revealed in part: 8. Nursing staff shall monitor and report any of the following side effects of the attending physician: sedation; orthostatic [MEDICAL CONDITION]; lightheadedness; dry mouth; blurred vision; constipation; [MEDICAL CONDITION]; increased psychotic symptoms ([MEDICATION NAME]); extrapyramidal effects; akathisia; [DIAGNOSES REDACTED]; tremor; rigidity; akinesia; or tardive dyskinesia Record review of facility provided policy titled Orders for Anticoagulants, dated January 2001, revealed in part: Policy Statement Orders for anticoagulants shall be prescribed only with proper clinical and laboratory monitoring. Policy Interpretation and Implementation 4. Nursing service must notify the physician if the resident has any internal bleeding (such as hematuria) or excessive bleeding. Record review of facility provided policy titled Physician Orders, dated June 2004, revealed in part: Policy Statement All physician orders [REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable on 2 out of 2 medication carts; and failed to ensure that controlled drugs listed in the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse were stored in separately locked, permanently affixed compartments in 1 out of 2 facility medication rooms. There were 3 loose medication tablets in the medication cart for halls A, E, and F. There were 2 loose medication tablets in the medication cart for halls B and C. There was a vial of [MEDICATION NAME] ([MEDICATION NAME]) in a medication room refrigerator that was not in a separately locked, permanently affixed compartment. The facility's failure could place residents at risk for drug diversion, drug overdose, and accidental or intentional missed doses or administration to the wrong resident. Findings include: During an observation and interview on 09/22/2020 at 11:25 AM with MA B, there were 3 medication tablets (1 white circular tablet and 2 white ovule tablets) loose in the second drawer down of the medication cart for halls A, E, and F. MA B reported that she had accepted responsibility for the cart at 7:20 AM that morning and that the carts are to be inspected and cleaned at the end of the shift by medication aides. MA B reported that there should not be loose medications in the medication carts. During an observation on 09/22/2020 at 11:35 AM with MA B, there were 2 loose medication tablets (1 grey ovule tablet and 1 white circular tablet) in the second drawer down of the medication cart for halls B and C. During an observation and interview on 09/22/2020 at 11:48 AM with DON, there was a vial of [MEDICATION NAME] concentrate 2 milligrams per milliliter in the medication room refrigerator. The vial was on the bottom shelf of the refrigerator next to, not inside of, a lock box. The refrigerator itself had a latch for a padlock, which was not locked at the time, and the padlock was hanging from the latch in the open position. DON reported that the refrigerator padlock should be locked and that the [MEDICATION NAME] vial should be locked inside the lock box in the refrigerator. The DON was asked about medication carts and reported that there should not be any loose medications in the medication carts. She reported that the night shift nurses are to clean out the carts during their shifts. During an interview on 09/22/2020 at 12:10 PM, DON reported that the loose medication tablets found in the facility medication carts had been identified as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676186	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE LTC PARTNERS INC	**1621 BUTLER DIMMITT, TX 79027**

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) [MEDICATION NAME], atorvastatin, [MEDICATION NAME], and memantine. Record review of facility provided policy titled Storage of Medications, dated January 2001, revealed in part: Policy Statement Drugs and biologicals shall be stored in a safe, secure, and orderly manner. Policy Interpretation and Implementation 1. Drugs and biologicals must be stored in the containers in which they are received. 9. All controlled substances are stored under double-lock and key. Record review of facility provided policy titled Controlled Substances, dated January 2001, revealed in part: Policy Interpretation and Implementation 5. Controlled substances must be stored in a separately locked container in the medication room. This container must remain locked when not in use. Record review of document by the United States Drug Enforcement Administration titled Controlled Substances, dated 20 August 2020, and retrieved from https://www.deadiversion.usdoj.gov/schedules/orangebook/c_cs_alpha.pdf, revealed that [MEDICATION NAME] is a controlled substance non-narcotic.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in 1of 1 kitchens when they failed to: A. Ensure stored food was properly labeled, dated and used or discarded before the expiration date. B. Ensure that residents personal fridge maintains an acceptable temperature. These failures could place residents who ate food served by the kitchen and their personal fridge at risk of cross contamination and food-borne illness. Findings included: Observation of the kitchen pantry on [DATE] at 10:55 AM revealed: 6 cans of Duraznos Amarillo's Tipo Pavia Melocotones Rebanados, unlabeled. 1 pack of 4 graham cracker pie crusts, unlabeled and open to air. 1 can of jellied cranberry sauce with a date of best by [DATE]. 1 can of jellied cranberry sauce with a date of best by [DATE], leaking onto the shelf. During an observation on [DATE] at 11:32 AM, the thermometer in the mini-refrigerator of room of Resident #19 indicated it was 58 degrees. In an interview on [DATE] at 11:00 AM, DM stated, we had someone new help with the shipment I told him to label everything, I prefer our usual employee who does the shipments since he knows what he is doing. In an interview on [DATE] at 11:50 AM, DM when asked about how often they check for expired items the DM stated, we get a truck in every Monday, so every Monday. During an interview on [DATE] at 1:28 PM, DM was asked who is responsible for ensuring appropriate temperatures of resident refrigerators. DM reported that activities or nursing should check temperatures of resident refrigerators. During an interview on [DATE] at 1:35 PM, AD C reported she does not know who is responsible to make sure resident refrigerator temperatures are within acceptable ranges to store food safely. During an interview on [DATE] at 1:39 PM, BOM reported that normally housekeeping will check refrigerator temperatures of resident refrigerators and clean out expired foods when they are cleaning rooms. During an interview on [DATE] at 1:43 PM, HSK D reported that housekeeping staff clean resident refrigerators, but they don't check temperatures. During an observation and interview on [DATE] at 1:50 PM, AD C inspected the refrigerator in the room of Resident #19. AD C confirmed that the thermometer in the refrigerator indicated that the current temperature of it was 60 degrees. AD C confirmed that the refrigerator was warmer than it should be. Record review for the facility's policy titled Food Storage dated [DATE], documented: 4. Food should be rotated as delivered and used in a First In, First Out method. Items will be dated on receipt to facilitate this procedure. Record review for the facility's policy titled, Refrigerators and Freezers dated [DATE] documented: 1.Acceptable temperatures should be 35F to 40F for refrigerators and less than 0F for freezers. 5. The supervisor will take immediate action if temperatures are out of range. Actions necessary to correct the temperatures will be recorded on the tracking sheet, including the repair personnel and/or department contacted. 8.Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufactures when expiration dates are in question or to decipher codes.