STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455968	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAHAM OAKS CARE CENTER	**1325 FIRST ST GRAHAM, TX 76450**

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services that meet the needs of each resident for 4 of 4 residents (Resident #'s 2, 3, 4, and 5), reviewed for pharmacy services. The facility failed to accurately and timely complete documentation of controlled drug administration for 4 residents (Resident #s 2, 3, 4, and 5). and monitoring of controlled medications stored on 2 of 2 Medication carts checked for narcotic reconciliation. This failure could place residents at risk of medication overdose, medication under-dose, and ineffective therapeutic outcomes. Findings included: Resident ID #2 Record review of Resident #2's Face Sheet, not dated, revealed Resident ID #2 was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review of Resident #2's active physician orders [REDACTED]. Record review of the Resident ID #2's MAR indicated [REDACTED]. Record Review of Resident ID #2's Narcotic count sheet for [MEDICATION NAME] 300 mg on 6/22/2020 at 2:10 PM revealed the documented count of the [MEDICATION NAME] 300 mg was 24 capsules. Observation of the medication card containing the [MEDICATION NAME] 300 mg capsules revealed a total count of 23 capsules. In an interview with RN#1 on 6/22/2020 at 2:10 PM she revealed she had not signed out for the medication on the narcotic sheet at the time of administration. She stated that the proper procedure for administration of any narcotic is to sign out on the narcotic control count sheet for the drug immediately after administering the medication. She stated she had just started at the facility today, and it had been very busy with multiple admissions during the morning. In an interview with Resident ID # 2 at 3:30 PM she stated she believed she had all of her medications that morning. Resident ID #3 Record review of Resident #3's Face Sheet, not dated, revealed Resident ID #3 was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review of Resident #3's active physician orders [REDACTED]. Record review of the Resident ID #3's MAR indicated [REDACTED]. Record review of Resident ID #3's Narcotic count sheet for [MEDICATION NAME] 0.25 mg on 6/22/2020 at 2:13 PM revealed the documented count of the [MEDICATION NAME] 0.25 mg mg was 76 tablets. Observation of the medication card containing the [MEDICATION NAME] revealed a total count of 75 tablets. In an interview with RN #1 on 6/22/2020 at 2:13 PM she revealed she had not signed out for the medication on the narcotic sheet at the time of administration. Resident ID #4 Record review of Resident #4's Face Sheet, not dated, revealed Resident ID #4 was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review of Resident #4's active physician orders [REDACTED].#4's MAR indicated [REDACTED]. Record review of Resident ID #4's narcotic count sheet for [MEDICATION NAME] extended release 5 mg capsules on 6/22/2020 at 2:15 PM revealed the documented count of the [MEDICATION NAME] extended release capsules was was 9 capsules. Observation of the medication card containing the [MEDICATION NAME] extended release capsules revealed a total count of 7 capsules. In an interview with RN #1 on 6/22/2020 at 2:15 PM she revealed she had not signed out for the medication on the narcotic sheet at the time of administration. Resident ID #5 Record review of Resident #5's Face Sheet, not dated, revealed Resident ID #5 was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Her face sheet revealed she was currently on hospice. Record review of Resident #5's active physician orders [REDACTED]. Record review of the Resident ID #5's MAR indicated [REDACTED]. Record review of Resident ID #5's narcotic count sheet for [MEDICATION NAME] 0.5 mg tablets on 6/22/2020 at 2:30 PM revealed the documented count was 54 tablets. Observation of the medication card containing the [MEDICATION NAME] 0.5 mg tablets revealed a total count of 53 tablets. Narcotic count sheet for [MEDICATION NAME] with [MEDICATION NAME] 5/325 mg tablets revealed a total of 22 tablets. Observation of the medication card containing the [MEDICATION NAME] with [MEDICATION NAME] 5/325 mg tablets revealed a total of 21 tablets. In an interview with RN #1 on 6/22/2020 at 2:30 PM she revealed she had not signed out for the medication on the narcotic sheet at the time of administration In an observation of Resident ID #5 on 6/22/2020 at 4:00 PM non verbal signs or symptoms of pain were not noted. She was relaxed and quiet. Record review of the 12 Hour Controlled Drugs Count Record for Carts A and B revealed blanks for signatures of on coming nurse and off going nurses on 6/19/20, 6/16/20, 6/17/20, 6/15/20, 6/14/20, 6/5/20, 6/3/20, and 6/2/20 . The nurses should have signed this form as documentaion that the narcotics had been counted by the on coming and off going nurses. An interview with the DON on 6/22/2020 at 3:00 PM revealed that she expected nurses to sign for controlled medication immediately when administering them, and to count narcotics with the on coming nurse at the end each shift with the oncoming nurse. The nurse coming on duty and the nurse going off duty should document they have counted on the facilyt form titled: 12 Hour Controlled Drugs Count Record. She stated she did not know that RN #1 had not signed for her controlled drugs when administering them. She verified that 6/22/2020 was RN #1's first day at the facility and stated she would in-service her immediately on the facility's controlled medication procedure. In a review of the facility's Policy and Procedure, provided by the DON, on 6/23/2020, dated 2003,titled Controlled Medication Procedure, documented (in part): All controlled medications will be stored under double lock and checked for accountability at each change of shift by the nurse going off duty and the nurse coming on duty. Documentation of the audit will be completed on the appropriate form. Evidence of the shift change audit must be maintained by the facility for 3 years. Disposition of controlled substances is maintained on the sheet supplied by the pharmacy with each schedule 2 controlled substance, and the controlled substances in schedules 3 and 4 provided in counters. Entries are to be made in pen each time a controlled substance is used. The nurse administering the medication will record the following information: date and time drug is administered, amount of drug administered, remaining balance of drug, and signature of nurse administering drug. If the pharmacy does not provide a controlled substance audit sheet, the nursing staff will utilize the facility's controlled drug audit sheet and fill in all of the required information from the prescription label of the medication audited. .

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.